COMMUNITY PLACEMENT AND CASE MANAGEMENT (CPCM) PROGRAMME MANUAL FOR UNACCOMPANIED AND SEPARATED CHILDREN (UASC)

FOREWORD

This Manual was put together by drawing from the policies, procedures and guidelines that we developed over the years for our on-going Community Placement and Case Management (CPCM) Programme for unaccompanied and separated children (UASC) in Malaysia. The Manual was written primarily as a practical and organised guide to help case managers provide effective case management services for UASC under their care.

In using this Manual, it is important to note that the type of population we work with has, to a certain extent, shaped the approach of this Manual. Firstly, as an organisation that actively advocates for alternative to detention measures in Malaysia, our Programme focuses on, and prioritises UASC who are at risk of immigration detention as they are regarded as vulnerable persons within the irregular migrant, refugee, asylum seeking and stateless populations. Most UASC in our Programme are between the ages of 15 – 18 years, are living in urban communities, and come from countries with turbulent histories, such as Myanmar, Afghanistan and Somalia.

Secondly, our approach in implementing the programme is also with the aim of working closely with the communities where most UASC come from, and to draw from the strengths of these communities in providing protection and care for these children. Therefore, our Programme emphasises community placements by engaging suitable caregivers from the community to provide needed care and protection for the children. We also engage leaders from the community who play the crucial roles of community case managers and interpreters in our Programme.

As Malaysia is not a signatory to the 1951 Refugee Convention, we acknowledge that most of the communities we work with are irregular migrants, refugees and stateless communities and generally do not have the support systems and structures in place for them to adequately cope with the daily challenges of living in Malaysia, let alone reach acceptable living standards.

As such, to successfully implement a community placement programme, it is strongly recommended that the organisation planning to implement the programme should take the position and view that every community can meet the expectations and standards of the roles and tasks given to them within the programme if given the necessary tools, resources, time and opportunities.

It is also important to provide adequate resources, guidance and supervision to help those engaged within the community to adopt the programme standards which may probably be above the level of the current cultural practices or skill sets within the community. Opportunities should be provided for the community to eventually meet all the expectations of the role entrusted them, especially as cultural practices require time for change.

We believe that by adopting this position, the expectation is that organisations which are engaged in this area of work should be willing to invest sufficient resources over a reasonable period of time to assist and support the community as the changes take place.

The production of this Manual would not be possible without the valuable contributions of the following organisations and individuals:

- The Asia Pacific Regional Coordinators of the International Detention Coalition, who have provided technical support for the development of the CPCM Programme and the Manual.

- Mr. Ng Chak Ngeng, a former program director of the Unaccompanied Refugee Minor Program of the Lutheran Community Services Northwest in Seattle, Washington, for his tireless advice, support and guidance in developing the CPCM programme and in reviewing this Manual.

- Reviewers, designers and proof-readers of the Manual.

- SUKA Society's Case Managers, both past and present, who have dedicated their time and effort in testing and providing feedback on procedures and tools included in this Manual. This has helped us to develop and adapt the processes and tools to ensure effective applicability on the field.

- The foster families participating in SUKA Society's Programme who continually encourage us to provide better support for foster families who have opened their homes to provide safer placement for UASC.

- The unaccompanied and separated children in SUKA Society's Programme who inspired us to embark on this project to implement a programme that provides better care and protection for UASC in Malaysia. We are grateful for all the UASC who have journeyed with us and those who continue to journey with us in developing the Programme.

An important core value of SUKA Society is that all tools and resources developed by SUKA Society are to be shared and can be used by any individual or organisation also providing protection and care for children in their community. However, the policies, procedures and guidelines in the Manual should be contextualised and adapted to fit your own organisation's framework, population of concern and country context. This Manual will also be reviewed and updated on a regular basis to remain relevant and adapt to the changing legal and socio-political climate of the country.

We hope that this Community Placement and Case Management Manual, and the Toolkit that will accompany this Manual will be a useful resource for any organisation interested in developing a similar community placement and case management programme. Do visit our website at www.sukasociety.org for further resources, or if you wish to contact us for further information.

SUKA Society
Malaysia

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A. GLOSSARY

No.	Terms	Description
1.	Abuse	The act of causing harm to another. Common forms of abuse include physical, sexual, emotional, verbal and/or psychological violence. The World Health Organization defines child abuse and maltreatment as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power". *Also see Maltreatment and Neglect*
2.	Adoption	Process of assuming the permanent care of and parental rights over a child from his/her biological parents. Under adoption, the responsibilities of the child's birth parents are legally terminated and transferred to the adoptive parents.
3.	Aged out	The process whereby a person reaches an age where he/she is no longer eligible to obtain specialized services for children. Within legal definitions of a child in Malaysia, a person, upon turning 18, will age out of the CPCM Programme and move into independent living. *Also see Independent living*
4.	Alternatives to Detention (ATD)	The International Detention Coalition defines Alternatives to Detention as "any legislation, policy or practice, formal or informal that ensures people are not detained for reasons relating to their migration status". ATD models are typically non-custodial options within a community based setting.
5.	Asylum seeker	A person who is seeking protection from serious harm in a country other than his/her own and whose refugee claim has yet to be assessed. *Also see Refugee*
6.	Best interest of the child	A child rights principle taken from Article 3 of the UN Convention on the Rights of the Child. The Article provides that all adults should do what is best for children. The principle guides decision making.
7.	Care plan	A written document that provides a list of goals that addresses the needs of the child and specific actions on how all parties will help the child achieve these goals.
8.	Care planning	The guided process to develop a care plan. *Also see Care plan*
9.	Caregiver	A person who provides direct care to a child. Also called a carer.
10.	Case Committee	A team that gathers to decide on the admission of a child into the programme. The team also decides on suggested interventions or goals related to the child that should be achieved throughout the case cycle. Members of the Case Committee should include the Case Manager, the Case Supervisor, the Project Director, and an independent child rights advisor. Decisions by the Committee must be objective, fair and in consideration of the best interest of the child.
11.	Case Management	A process of identifying and coordinating services to address the holistic needs of a person. Case Management processes include the screening, assessment, planning, care coordination, facilitation, monitoring and evaluation of a person's risks, needs and related concerns. Case Management specifically related to children should look into the safety, stability and permanency and well-being needs of a child.
12.	Case Manager	A person whose primary role is to facilitate the process of case management.
13.	Case Supervisor	A person who assists with guiding, advising and overseeing the work of Case Managers. The Case Supervisor also plays a decision making role.

No.	Terms	Description
14.	Child	A person below the age of 18 years old, unless otherwise stated by law. In Malaysia, a child is defined as a person below the age of 18. *Also referred to as a "minor".*
15.	Community representative	A leader from a particular community that is identified as representing a significant segment of that community.
16.	Community placement	Community placement within the programme context is defined as community based care for unaccompanied and separated children. One such example is foster care.
17.	Community-based-organizations (CBO)	A not-for-profit group that works from a society or community level and works to meet the needs of a particular community. Within the Malaysian context, CBOs are refugee community led and are typically differentiated based on ethnicity or nationality.
18.	CPCM Programme	The Community Placement and Case Management (CPCM) Programme is a two phased programme by SUKA Society that looks into foster care placement and provision of case management services for UASC in Malaysia.
19.	Durable solutions	Finding solutions that enable refugees to rebuild their lives with dignity and respect. Three main aspects of durable solutions include resettlement, repatriation and integration. Durable solutions in Malaysia are undertaken by the UNHCR. *Also see Resettlement and Repatriation*
20.	Family reunification	The act of preserving a family unit. Family reunification is often needed when family members are separated within a migratory context. Reasonable efforts must be made to trace and reunite a child with his/her biological parents or primary caregiver where appropriate and in the best interest of the child.
21.	Formal foster care	Where the Court grants the State the right to take temporary custody of a child and to arrange for relevant foster care arrangements accordingly. The change of care and custody is legally authorized and regulated by the State or a foster care agency.
22.	Foster care	Temporary care provided when a child's parents, legal guardian or customary care provider is unable to care for the child. Foster care can take many forms. *Also see Formal foster care and Informal foster care*
23.	Foster parents	Persons who are not the biological parents or relatives of the child but to whom care and control of the child has been given by the relevant authorities. Foster parents provide temporary care for a child in the community.
24.	Foster Parents Support Worker	The personnel of the agency that looks into supporting the foster parents throughout the fostering process.
25.	Guardian	A person who has the right and responsibility of taking care of someone who cannot take care of himself or herself.
26.	Heightened risk	The increased risk of harm experienced by particularly vulnerable groups of persons. UASC are often at increased risk of abuse, maltreatment, neglect, exploitation and other forms of violence within a migratory context.
27.	Home Study	A review of the foster parents, the foster home and family environment. The Home Study is completed by the Foster Parents Support Worker and will be used during the foster parents' selection process.
28.	Home visit	A visit to a person's home made by a Case Manager.
29.	Immigration detention	A government run facility that holds persons who have violated immigration laws of a country. In Malaysia, children are held with the adult population in immigration detention centres across the country.

No.	Terms	Description
30.	Independent living	The preparation for a child to achieve self-sufficiency prior to or upon exiting the Programme. During case management, a child is assisted with developing the skills he/she needs for adulthood and independent living.
31.	Informal foster care	A private and temporary arrangement between a child's parents and another party which is usually a family member, a relative or family friend. The transfer is not overseen by the State or a family court and there is no change in legal responsibility of the child. Also see Formal foster care
32.	Intake interview	The initial meeting during which the Case Manager asks relevant questions to gather information to identify the client's needs and risks.
33.	International Organization for Migration (IOM)	An intergovernmental organization that provides services and advice concerning migration to governments and migrants. Within the Malaysian context, IOM assists with the resettlement process for refugees and the repatriation process for migrants.
34.	International Committee of the Red Cross (ICRC)	An independent international organization that ensures humanitarian protection and assistance for victims of war and armed violence. Within the programme, the ICRC mainly assists with tracing and family reunification.
35.	Intervention	The action carried out to address a particular need or to fulfil a particular goal.
36.	Irregular migrants	The IOM defines this as persons who undertake "movement that takes place outside the regulatory norms of the sending, transit and receiving country." Irregular migrants often do not have valid documentation and are at risk of arrest and detention.
37.	Maltreatment	All forms of abuse and neglect. Child maltreatment relates to all forms of abuse and neglect towards a child. Also see Abuse and Neglect
38.	Matching Committee	A team formed by the agency to select a foster family that best fits the profile of the child. Composition of the Committee should, at the very least, include the Case Manager, the Case Supervisor, the Foster Parents Support Worker and an independent expert on child care.
39.	Minor	A person below the age of 18 years old, unless otherwise stated by law. In Malaysia, a child is defined as a person below the age of 18. Also see Child
40.	Neglect	A form of abuse where a person's basic needs are not met. Child neglect include the failure to provide for a child's safety needs, access to adequate healthcare, clothing and other material needs, emotional and social development needs, and educational and housing needs. Also see Abuse and Maltreatment
41.	Non-governmental organization (NGO)	A not-for-profit organization that operates independently from the government and whose purpose is typically to address social or political concerns.
42.	Permanency goals	Finding longer term solutions for a child as a result of disruption in a child's life from the migration process. Also see Stability goals
43.	Project Director	A person who assists the Case Supervisor and provides overall direction for the Programme.
44.	Quality Assuarance Worker	Personnel of the agency who oversees case and programme evaluation under a foster care programme.
45.	Rapport building	An ongoing process for building trust, establishing common ground, demonstrating empathy and understanding, and opening up channels of communication with a client.

No.	Terms	Description
46.	Refugee	A person who has been forced to flee his/her country because of persecution, war or violence. Such persons must have a well-founded fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group. As a result of this fear, such persons are also unable to obtain protection from the State authorities.
47.	Repartiation	The return of a person to his/her own country.
48.	Resettlement	The process of moving people, usually refugees, from an asylum country to another country that has agreed to accept them.
49.	Risk assessment	A systematic process of assessing the potential and actual risks involved in view of reducing the harm that results from these risks.
50.	Safety goals	Goals that ensure children who are outside of home care are safe from abuse, neglect, and maltreatment.
51.	Screening process	Preliminary assessment to determine the suitability of an applicant. Foster parents are screened mainly for safety requirements whilst a child is screened only for programme requirements. Screening allows for the right persons to be referred into the programme.
52.	Sexual and Gender Based Violence (SGBV)	Any act - physical, emotional, psychological or sexual in nature - that is carried out against a person's will. The violence carried out is based on gender norms and unequal power relationships that can affect women, girls, men and boys.
53.	Shelter or residential care	Group living arrangements where children are looked after by a paid staff in a specially designated facility. Residential care should always only be provided on a temporary basis. However, in Malaysia, most residential care services function as longer term solutions for children.
54.	Stability goals	Goals that look into reducing the number of disruptions in a child's life and to provide some form of stability that was lost through the migration process.
55.	Stateless person	Article 1 of the 1954 Convention relating to the Status of Stateless Persons defines a stateless person as someone who is not considered a national by any State under the operation of its law. Some refugee populations are also considered to be stateless.
56.	Survivor of Violence and Torture (SVT)	A person who has experienced or witnessed serious forms of torture and/or violence. Violence is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm...". Torture is defined under Article 1 of the UN Convention against Torture (UNCAT) as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind...".
57.	Trauma	A person's emotional and physical response to highly distressing experiences or events. Such events usually involve significant loss, emotional or physical harm or the threat thereof.

No.	Terms	Description
58.	UN Convention on the Rights of the Child (UNCRC)	United Nations Convention on the Rights of the Child is a human rights treaty that sets out the civil, cultural, legal, health, political and social rights of children. Countries that have ratified the Convention are expected to advance the implementation of the Convention and the status of child rights in the country. Malaysia ratified the Convention in 1995.
59.	United Nations High Commissioner for Refugees (UNHCR)	The United Nations refugee agency mandated to protect refugees, asylum seekers, forcibly displaced persons, and stateless persons.
60.	Unaccompanied and separated child (UASC)	An unaccompanied child is a person below the age of 18 who is separated from both parents and is not being cared for by an adult who under law or custom has the responsibility to provide such care. A separated child is person below the age of 18 who is separated from both parents, guardian or primary care giver but is in the country with other adult relatives.
61.	Undocumented person	A person who does not have the appropriate documentation and/or legal right to reside in a country.
62.	Vulnerabilities	Qualities or a state that exposes a person to being harmed or persecuted. Examples of persons who are considered to be vulnerable groups include unaccompanied children, survivors of violence and torture, persons with disabilities and the elderly.
63.	Well-being goals	A holistic and broad way of describing how a person is doing. It is often related to the extent the basic rights of a person are being met. Child well-being goals will include goals related to physical and mental health, material needs, risk and safety, social support, education, housing, and child participation.

B. INTRODUCTION

1. Overview and Principles

The Community Placement and Case Management (CPCM) Programme aims to provide a holistic case management system that specifically looks into the protection concerns of migrant, undocumented, stateless, refugee, and asylum seeking Unaccompanied and Separated Children (UASC) at risk of arrest and detention and those directly affected by immigration detention in Malaysia.

Community placement in this context refers to the community-based accommodation that a refugee, asylum seeking, migrant or undocumented UASC would be placed in. Such community based accommodation is central in preventing immigration detention and ensuring UASC are in safe and stable housing.

Case Management is seen as a process wherein a Case Manager:

forms working relationships with individuals and families to empower, enhance their wellbeing and problem-solving capacities, resolve outstanding issues, provide information on how to obtain services and resources in their communities, and work towards the protection of people who are not in a position to do so themselves...[1]

Case Management within a child protection framework has been defined as:

The method of assessing the needs of the child and the child's family and current caregiver, advocating for, arranging, coordinating, monitoring and following up on both direct services and referrals required to meet the child's complex needs.[2]

Case Management for UASC within a migratory context encompasses the above through a holistic system that offers a continuum of services that does not end until a durable solution or case resolution is achieved.

CPCM Programme Values

Values provide a basis that guides organizational practices. The CPCM Programme and SUKA Society's values are guided by the guiding practices provided under the 1989 UN Convention on the Rights of the Child (UNCRC) – which include:
i.   the principle of non-discrimination (Article 2),
ii.   the principle that the best interest of the child is of paramount importance in all decisions affecting children (Article 3),
iii.   the right to participation and inclusion in the case management process (Article 12),
iv.   the basic right to survival and development (Article 6).

Other values include:
i.   that the individuality and uniqueness of a child is recognized, respected, and taken into consideration in the decision-making process,
ii.   that the programmes and services are able to develop a child's abilities and skills leading to an independent adult life,
iii.   that the relevant stakeholders undertake their roles and responsibilities to a standard that actively works towards safeguarding a child's best interest.

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1   Corlett, D., with Mitchell. G., Van Hove, J., Bowring. L., Wright, K., Captured Childhood, Melbourne, International Detention Coalition, 2012. Retrieved from: www.idcoalition.org/ccap.
2   Interagency Working Group on Unaccompanied and Separated Children, Alternative Care in Emergencies Toolkit, published by Save the Children on behalf of the Interagency Working Group on Unaccompanied and Separated Children, 2013. Retrieved from: https://www.unicef.org/protection/files/ace_toolkit_.pdf.

CPCM Programme Principles

Principles provide guidance to an organization when developing its processes or programmes. The outcome of the organizational values above are reflected in the programme principles stated below:

Figure 1 Programme principles guided by organizational values

More specifically, the programme framework focuses on the following guiding principles: [3]

- A System that is **CLIENT CENTRIC**, with the client (the child in this instance) as the focus of the framework and service response to ensure that individual needs are met. The client also takes an active role in developing a care plan and services needed.
- A System that is **PROACTIVE** by responding in advance to needs and risks; to be preventive rather than reactive.
- A System that is **STRENGTHS BASED** by identifying a client's assets, resiliency and resources, and building on these systems and coping mechanisms.
- A System that is based on a respectful and mutually beneficial **PARTNERSHIP** between the client, family, community, Case Manager, any other service provider, government and non-government agency.
- A System that is **HOLISTIC**, taking into account all the needs of the client including physical, psychological, spiritual, cultural and social needs.
- A System that is **OUTCOMES DRIVEN** by focusing on client goals, and through continuous monitoring and review of actions.
- A System that is **CULTURALLY RESPONSIVE**, respectful, and relevant to the client's cultural identity, which includes race, ethnicity, gender, age, country of origin, language, disability, spiritual and cultural beliefs, economic status, family and community needs.
- A System that is **DYNAMIC** and allows for the revision of goals and strategies based on case progression and the client's changing circumstances

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3   These principles have been adapted from the Case Management Manual of the Department for Communities and Social Inclusion of the Government of South Australia. The Case Management Framework: Specialist Homelessness and Domestic and Aboriginal Family Violence Services (SHS), Homelessness Strategy Division, Housing SA, Department for Communities and Social Inclusion, July 2013. Retrieved from: https://dhs.sa.gov.au/ __data/assets/pdf_file/0005/60593/Case_management_ framework.pdf.

CPCM Programme Goals

CPCM goals are typically organization specific and adapted based on the challenges faced within a country context. For this Manual, goals are developed based on the child welfare framework for UASC adopted from the U.S. model. The goals primarily focus on establishing safety, stability and permanency, and meeting the overall well-being needs of a child that is placed in the community or in out-of-home care.[4] Principles of the programme above are reflected in specific goals relevant to the client.

a) Safety Goals

A core function of the programme is to ensure that every child in out-of-home care is safe. Safety goals include interventions that protect a child from actual or threat of harm, and the minimization of risk of harm in the out-of-home care environment. More specifically, the goals should include physical protection, where a child lives in a safe environment without threat or actual presence of abuse, maltreatment or neglect, and that a child has the necessary skills to protect himself/herself. Contingency and safety plans should be developed with the caregiver and the child.

b) Stability and Permanency Goals

Stability and permanency goals look at helping a child restore the stability that was lost as a result of the migration process or separation from his/her parents or formal caregiver. Interventions should provide a state of stability and a permanent home for the child as well as achieving permanency from a longer term perspective. Achieving stability and permanency in a transit country context is challenging. In such a context, it may include the following:

Stability:
  i. Establishing family and community links where possible.
  ii. Securing alternative placement of care in the community, either via foster care arrangements with community members or independent living for the older minors.

Permanency:
  iii. Legal protection in the country of transit.
  iv. Working towards a durable solution, which may include resettlement, repatriation where possible, local integration, and/or preparation for ageing out of the programme and continued independent living into adulthood.

c) Well-being Goals

Child well-being goals are a holistic and broad way of describing how well a child is doing. Andrews et al. (2002) defines well-being as:

...healthy and successful individual functioning (involving physiological, psychological and behavioural levels of organisation), positive social relationships (with family members, peers, adult caregivers, and community and societal institutions, for instance, school and faith and civic organisations), and a social ecology that provides safety (e.g. freedom from interpersonal violence, war and crime), human and civil rights, social justice and participation in civil society.[5]

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4   Adapted from the national goals under the Adoption and Safe Families Act of 1997, United States of America.
5   Andrews, A., Ben-Arieh, A., Carlson, M., Damon, W., Dweck, C., Earls, F., Garcia-Coll, C., Gold, R., Halfon, N., Hart, R., Lerner, R.M., McEwen, B., Meaney, M., Offord, D., Patrick, D., Peck, M., Trickett, B., Weisner, T. and Zuckerman, B. (Ecology Working Group) Ecology of Child Well-Being: Advancing the Science and the Science-Practice Link. Georgia: Centre for Child Well-Being, 2002, p.103.

Child well-being has been framed in many different ways by different authors over the years. For the purposes of the current country context, well-being is adapted and developed around the basic tenants of children's rights contained in the UNCRC – the right to Survival, Protection, Development and Participation. Well-being goals are measured across seven main domains:

Material well-being

Physical health
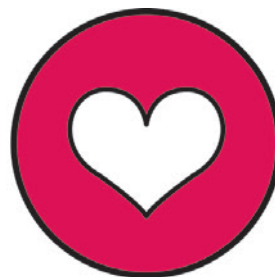
Subjective well-being

Education

Housing

Relationships and support systems

Risk and Safety

i. Material well-being – adequate food, clothing and other basic essential items
ii. Physical health – current health and access to health care
iii. Subjective well-being – emotional and mental health
iv. Education – access to education
v. Housing – safe and adequate living conditions with basic amenities
vi. Relationships and support systems – developing and strengthening primary and secondary support circles
vii. Risk and Safety – reduction in risk/threat of harm and arrest by authorities for immigration offences.

2. Scope of the Manual

This Manual is meant to be an instructional and informational guide for organizations looking to set up a community placement and case management programme. It aims to provide a basic framework for organizations with standard operating procedures detailing relevant actions and assessment forms to guide Case Managers, supervisors and other support staff.

The scope of the Manual is limited to the following client profile:

- unaccompanied or separated minor,
- below the age of 18,
- at risk of arrest and detention for immigration related purposes, and
- currently living in the community.

Although the Manual endeavours to be a comprehensive guide, organizations should adapt relevant processes, procedures and tools to fit the organization's needs, country context, and the population served. The Manual also does not take into consideration and cannot address the many factors that create a rich diversity in a case management and community placement process including: the unique traits and characteristics of specific children, differences in approaches and responses to case resolution, local political and legal conditions, and individual management styles, to name a few. As Malaysia is not a signatory to the 1951 Refugee Convention, and does not have any organised State programme for the protection and care of UASC in the country, the scope of this Manual is limited to processes, procedures and tools that are available to civil society organizations, local communities and international agencies.

MALAYSIA CONTEXT AND SUKA'S CPCM PROGRAMME

As there are no refugee camps in Malaysia, most refugees and asylum-seekers live in small, cramped flats or houses in the city. Following a lack of a protection space in the country and the absence of suitable caregivers, UASCs are at significant risk of abuse, violence and trauma. Undocumented UASCs are particularly at risk of arrest and detention, and those that are released from immigration detention struggle to find safe placement and access basic services. Further undocumented and documented refugees, asylum seeking and migrant persons often experience significant challenges in accessing national protection systems.

Apart from interventions by UNHCR to secure release, there is little to no coordinated support for UASC upon their release from detention. Further, support for undocumented UASC within the communities is limited based on capacity and resources of community organizations and limited non-governmental service providers. At present, there are no specific non-governmental or community based organizations working solely to address the needs of UASC and to our knowledge none that use a holistic case management approach.

In light of this, SUKA Society has implemented a community placement and case management programme specifically for undocumented UASC living in the community who are at risk of arrest and detention. The Programme is a work in progress with tools and processed being developed over time. These tools and processes continue to evolve and improve over time.

At time of writing, there have been over 150 UASC referred and screened. Due to the mandate and availability of resources, the scope of the programme is limited to unaccompanied or separated minors below the age of 18, who are at risk of arrest and detention for immigration related purposes and who currently reside in precarious or unsafe housing in the community.

You are encouraged to approach your work with sensitivity, creativity, and resourcefulness to develop specific strategies that do take into account all of the many variables that influence the specific needs of your clients. In addition, where available, you are also encouraged to tap into opportunities to incorporate government resources, processes and services to create a collaborative "working together" process between government and civil society agencies. It is up to you to take the basic framework outlined in this Manual, and build a programme that effectively addresses the needs of your clients. This Manual is designed simply to serve as the foundation from which to begin.

3. How to Use this Guide

The Manual consists of four main parts:

1. **Laying the Programme Foundation**
   Outlines the relevant elements needed to set up a community placement and case management programme for UASC.

2. **The Case Management Process**
   Outlines the processes and procedures to undertake case management services for UASC.

3. **The Community Placement Process**
   Outlines key aspects of a foster care placement including the roles and responsibilities of key stakeholders and the relevant procedures in the selection and matching of foster parents.
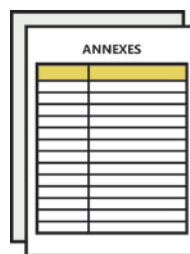
4. **Annexes**
   A range of tools to assist in the implementation of the Programme.

The tools and processes are meant to facilitate the process of planning and implementing a community placement and case management programme for UASC. The Manual should therefore be seen as a starting point to develop and contextualise as appropriate, based on your organizational needs and country context. This Manual also forms a part of a larger toolkit that is being developed for the care and protection of UASC in a displaced context.

C. THE GROUNDWORK: LAYING THE PROGRAMME FOUNDATION

1. Programme Snapshot

Description
The CPCM programme involves two parallel processes that will need to be put in place for a child to be safe and protected. The two processes are the case management process and the community placement process. Both processes, although somewhat independent, will converge at a point as demonstrated in the diagram on page 19.

The Case Management Process
The case management process endeavours to be a client-centred, goal-oriented process, which assesses the needs of clients for particular services and assists them in obtaining these services. This process continues until a durable solution or case resolution is achieved based on outcomes that are in the best interest of the child, or upon a child turning 18 and ageing out of the programme.

STEP ONE
The case management programme receives referrals of UASC from concerned members of the public, UNHCR, NGOs and relevant authorities.

STEP TWO
Intake and risk assessment is conducted to obtain information regarding the challenges and needs of the UASC. The intake and risk assessment covers the three areas of safety, permanency and well-being.

STEP THREE
A case plan is developed together with all relevant stakeholders. The UASC's challenges and needs, such as the need for a caregiver or foster family, safety, legal status, food, education, and health care are addressed.

STEP FOUR
Intervention based on the case plan is then carried out to ensure that the UASC receives all the needed support, care and protection.

STEP FIVE
The goal of the case management programme is to ensure that each UASC's case is resolved according to the principle of the best interest of the child. Case resolution can mean resettlement to a third country, independent living for those who become adults or returning home when it is safe to do so.

Figure 2 Summarized version of the case management process

Case referrals may include referrals from government, non-governmental, community based organizations, and UN agencies. Case management services in relation to protection and case resolution may differ based on the immigration status of the child, the specific country context and available resources.

The Case Management Process will include the following:

Phase 1	Referral Process
Phase 2	Screening Process
Phase 3	Rapport Building and Intake Process
Phase 4	Assessment Process
Phase 5	Rapport Building and Care Planning Process
Phase 6	Implementation of Care Plan or Intervention Process
Phase 7	Monitoring and Reassessment Process
Phase 8	Termination and Case Resolution Process

The Community Placement Process

The community placement process works towards finding permanency and stability in terms of a child's home environment. There are various options for community placement, including foster care placement, kinship care or informal foster care, independent group homes for older UASC, and in certain circumstances, residential care when it is in the best interest of the child. Community placement options for a child must be carefully assessed to ensure it is in the best interest of the child. Community placement options should also meet basic minimum standards of care, and have adequate monitoring and follow up assessments.

Below is a suggested flow chart for the CPCM Programme with a foster care community placement model and case management model. Note that these processes may differ based on the specific circumstances or variables of a child's situation. The foster care community placement model provides processes that a foster parent will need to go through while the case management model provides processes applied to a child. The following processes will be further explained in the Manual.
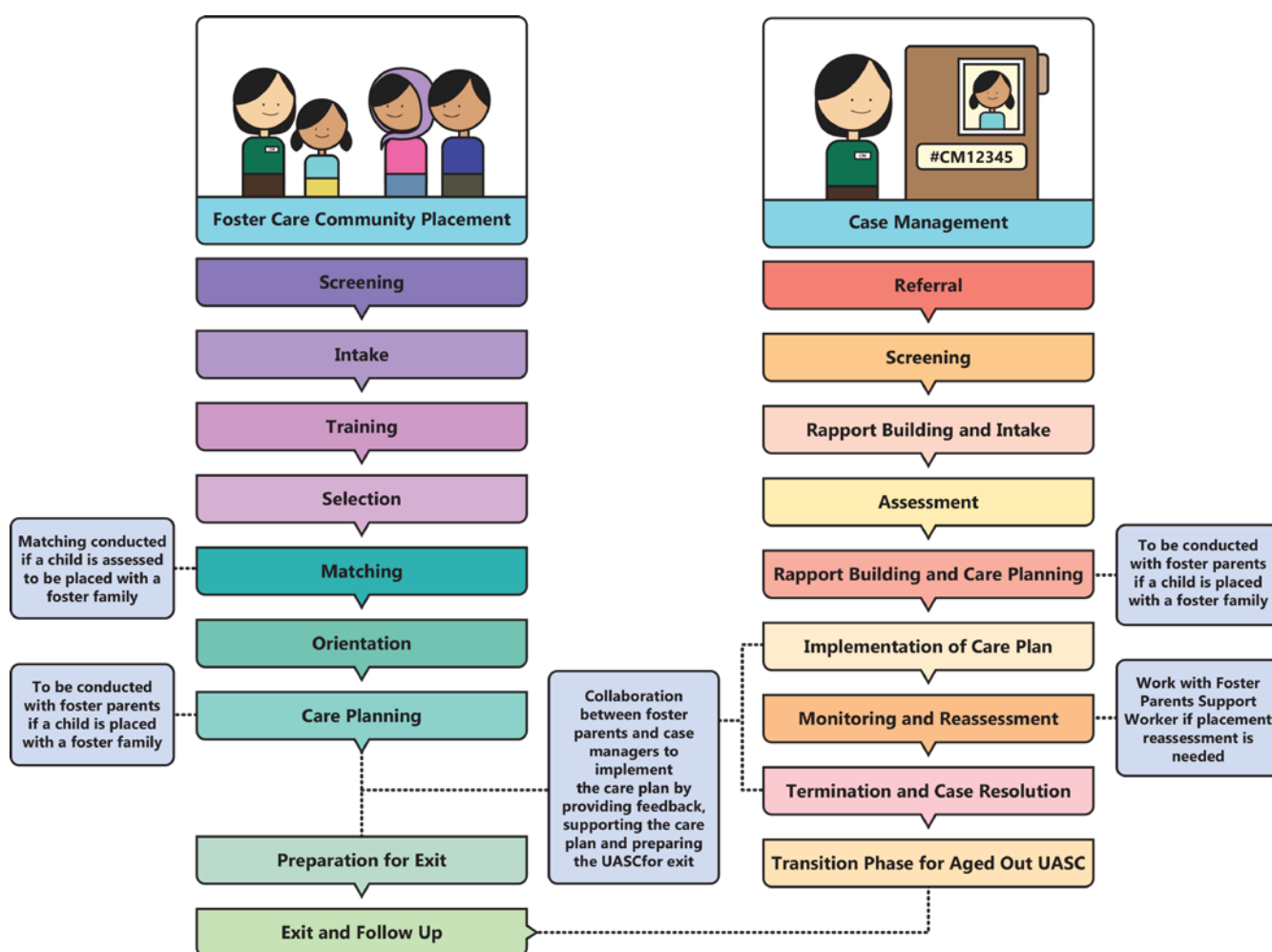
Figure 3 Overall programme flow chart for a foster care community placement and case management process. The flow chart provides points where the parallel processes will converge.

2. Getting the Right People

Description

A key step in setting up the programme is ensuring that the right people are hired to implement the programme. Depending on the country context and resources, it is recommended that a 1:18 Case Manager to client or case ratio be adopted. It is recommended that there are male and female Case Managers to address the different needs of male and female clients accordingly. It is also recommended that there are no more than five Case Managers per supervisor to manage. Below is a list of recommended key personnel roles and responsibilities, as well as the supervision and reporting frameworks.
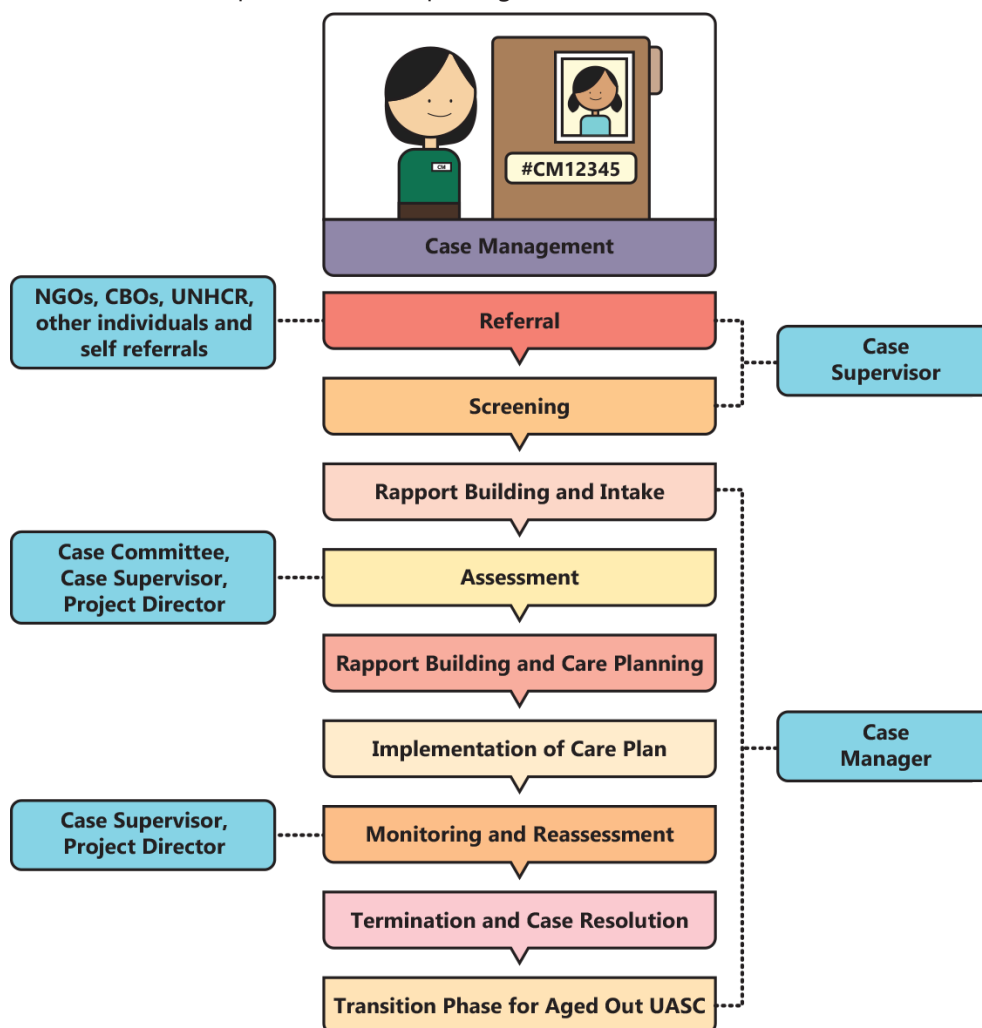
Figure 4 Key stakeholders involved in the case management process.

Personnel

a) The Case Manager

Roles and Responsibilities

The effectiveness of a case management system is very much dependent on its Case Managers. As a Case Manager, he/she will have direct contact with the client and will be expected to empower clients and ensure that their best interests are always upheld. A Case Manager will be expected to conduct all home visits, oversee coordination of services, ensure the protection and promotion of the client's best interest until a durable solution or case resolution is achieved, complete all relevant reporting mechanisms, and consult the Case Supervisors, and/or other colleagues when necessary.

As clients are children and come from traumatic backgrounds, all Case Managers will be expected to read, comprehend, sign and strictly adhere to the organization's Child Protection Policy (**Annex 1**) and Confidentiality Agreement (**Annex 2**). Contravention of these policies can result in the termination of employment. The working relationship with each child should be a partnership based on mutual respect and trust. As much as possible, the Case Manager will jointly problem solve and work together with the client to develop a care plan to empower and address the needs of the client.

Case management responsibility may entail all or some of the following in any given case:

a. Establish a positive rapport and working relationship with clients and referral agencies.

b. Ensure the protection of clients' privacy and confidentiality at all times. All case notes are to be stored in an appropriate manner.

c. Provide an environment where the client can feel safe when confronting difficult issues, attitudes and behaviours.

d. Carry out home visits as required, based on the suggested timeframes and frequencies.

e. Conduct safety assessment of community placement on each home visit to ensure that the placement continues to be safe and is nurturing for the child.

f. Complete all relevant intake forms and assessments as required, paying attention to the needs and particular vulnerabilities of the clients.

g. Work with, guide, facilitate and empower clients to problem solve - identifying strengths and barriers, developing goals and an individualized care plan to reduce non-compliance and ensure the needs of the clients are addressed.

h. Assist each child and their care providers to make a safety plan in the event of an emergency.

i. Monitor and document individual progress towards goals within the care plan.

j. Reassess goals and care plans on a regular basis. Provide monthly reports to the Case Supervisor on this monitoring and reassessment exercise.

k. Identify community and other resources to meet needs of clients. Utilize mapping database of services that are publicly available.

l. Refer clients to the appropriate service providers based on their needs and/for follow up assessments as needed.

m. Coordinate case management with other non-governmental service providers, government and UNHCR or ICRC teams through regular personal contact and the exchange of written information with these agencies.

n. Participate in regular monthly and/or bi-weekly meetings with other Case Managers and Case Supervisors to discuss issues and to report on progress of clients.

SUKA CONTEXT: CASEWORK HOURS

To develop recommended casework hours for Case Managers, casework practices were tracked over a 6 month period using a time sheet. Data from the time sheet was then coded and analyzed. A recommended distribution of casework was then developed in line with the maximum number of work hours required by staff per month. A proposed Case Manager to client ratio was also developed based on the work hours.

Casework hours are distributed based on non client contact hours (for example coordination work and other SUKA related work) and individual client contact hours based on the type of case and interventions. It is recommended that Case Managers have 78% of their time allocated to individual client contact hours. Of this 78%, it is recommended that 50% of that time is apportioned to new cases as time is needed to stabilize a case.

Although it is not an exact science, developing recommended casework hours for your Case Managers will ensure more efficient use of time, assist with fair distribution of work, and may prevent staff burnout.

o. Maintain case files and ensure individual softcopy and hardcopy files are organized, detailed, and up to date with relevant information on the client's progress.

p. Provide reports as required to funders and/or any other implementing agency.

q. Any other responsibility deemed reasonably necessary to carry out the case management process.

In addition to the above, a Case Manager may have additional responsibilities when a child is placed in a foster family. This will include the following:

a. Conduct regularly scheduled and unscheduled visits to the foster home and check with the child to ensure that the child is safe and that the Minimum Standards of Care prescribed by the Foster Care Agency are met.

b. Work closely with the foster parents and the child in developing the care plan and putting it into practice.

c. Encourage the child to develop and maintain a healthy and positive relationship with his or her foster parents and other family members in the household.

d. Keep the foster parents updated regarding the implementation of the care plan, the child's status in the foster care programme, progress of case resolution, and any other issues raised during the Case Manager's contact with the child.

e. Work with the foster parents when the Case Manager is unable to work directly with the child because of the child's limited maturity or his/her diminished capacity.

f. Work with the Foster Parents Support Worker by providing necessary feedback from the child's perspective in plugging gaps in delivery of care by the foster parents.

g. Regularly conduct care plan reviews with the child and the foster parents.

h. Support foster parents during emergencies or whenever the child is ill and requires medical intervention.

Selection
Case Managers must possess the following criteria:

a. Minimum diploma level qualifications in Social Sciences or its equivalent, or some experience working with children from refugee, asylum seeking, migrant, and/or stateless communities.

b. Have a basic understanding and able to work with children, particularly children from immigration detention and at-risk children from marginalized communities.

c. Able to adapt to diverse cultural and social situations or backgrounds.

d. Experienced or able to work on community placement, case management process and long term follow up.

e. Able to network, communicate and develop referral processes with clients, other service providers and agencies.

f. Have a basic understanding of child protection, children's rights, and child development.

g. A willingness to adhere to ethical guidelines, child protection policies, and respect confidentiality agreements with the client and partners.

h. Able to work in a team.

i. Able to adhere to periodic reporting timelines and home visits, as needed.

j. Able to cope with challenging behaviours and situations.

k. Demonstrates a willingness to be proactive and to be self-directed.

l. Experience in communication and conflict negotiation skills is an added advantage.

m. Able to speak and write adequately in English.

n. Have basic computer skills for case management reporting and documentation.

o. Ability to speak any other languages specific to the population is an added advantage.

b) Case Supervisor

Roles and Responsibilities
The Case Supervisor has similar responsibilities as the Case Managers above but with the additional responsibility of supervising and monitoring Case Managers, the client intervention progress, and directly reporting to funders or implementing agencies. More specifically, a Case Supervisor's responsibility will entail all/some of the following:

a. Providing supervision for the Case Managers to ensure Case Managers follow acceptable standards, including those prescribed in this Manual, and relevant standard operating procedures prescribed by the organization.
b. Ensuring that the overall case load for Case Managers is within reasonable limits so that Case Managers are able to meet expected roles in an efficient and effective manner.
c. Developing the overall direction for the programme to ensure activities are carried out in the best interest of the child.
d. Monitoring and evaluating the programme to ensure the programme meets the standards prescribed in the Manual.
e. Problem solving and resolving conflicts, challenges and issues that come up with regards to the cases.
f. Monitoring of the budget and grant reporting on the programme, where needed.
g. Reviewing case reports and assessments carried out by the Case Managers.
h. Coordinating Case Conferences and Case Committee meetings with relevant stakeholders.
i. Engaging and networking with relevant stakeholders to create opportunities for the Case Managers to coordinate interventions.
j. Coordinating capacity building for Case Managers and other relevant persons involved in the case, including the foster parents.

c) Project Director

Roles and Responsibilities
The Project Director's responsibilities may entail the following:

a. Provide supervision of the Case Supervisor to ensure the programme is implemented in an efficient and effective manner, and according to acceptable standards.
b. Evaluate overall progress of the programme in meeting the objectives and intended impact.
c. Overall strategic planning and development of the programme, along with organization planning and development.
d. Problem solving and resolving conflicts, challenges and issues that come up with regards to the programme and staff.
e. Provide guidance, direction and mentorship for the Case Supervisor.
f. Participate as a member of the Case Committee and actively engage in the decision making process.

d) Case Committee

Roles and Responsibilities

A Case Committee will be established to discuss individual cases via a Case Conference. Decisions will be made in the best interest of the child. Representatives of the Case Committee will include Case Managers, the Case Supervisor, the Project Director, an external consultant or expert, and where possible, relevant representatives from the referring agency. The Case Committee may call the following types of Case Conferences:

a. Admission Case Conference – to decide on new referred cases for admission into the programme, the suitability of community placement, and other relevant interventions needed.
b. Case Review Case Conference – to review care plans and progress of existing and transitioning out cases.
c. Emergency Case Conference – to review a case following an incident and to determine what follow up action is required.

Case Management Supervision and Reporting

Each Case Manager will be assigned to a Case Supervisor and will report directly to the said Case Supervisor who will supervise the Case Manager's cases. In the absence of the allocated Case Supervisor, or when urgent consultations are needed, the Project Director will assist in managing the process. All reports by Case Managers should be provided to the Case Supervisor, as necessary.

The Case Supervisor will schedule monthly meetings with all Case Managers to debrief and discuss case progress. Individual meetings between an individual Case Manager and the Case Supervisor must also be scheduled once a month, or following a specific incident or emergency situation with a case. The Case Supervisor will, in turn, provide monthly updates to the Project Director.

As a check and balance, Case Managers may use the supervision tool in **Annex 3** as a checklist to assess if they are carrying out their functions and responsibilities adequately. The Case Supervisor or Project Director may also use the supervision tool to provide constructive feedback on the work of their Case Managers, and assist them in addressing any gaps or challenges in service provision. Hardcopies of this assessment and feedback, regarded as confidential, will be stored by the relevant administrative staff.

Handover or Case Manager Transition

Before a Case Manager leaves, a transition process will be initiated. All documentation and client folders must be up to date and accurate. A handover document must be prepared and everyone in the team, including the Case Supervisor, must be briefed before a Case Manager's departure from the organization. To ensure continuity in the Case Manager-client relationship, a new Case Manager will be assigned to the client and will shadow the exiting Case Manager on home and referral visits with the client for at least three months. The Case Manager will also need to clearly brief the client on the change of circumstances.

3. Capacity Building

Continuous training is an important aspect for all personnel working on community placement and case management. All relevant personnel should receive training to build key skills and knowledge in one or more of the following areas:

1. People Skills
   a. Working with children
   b. Interviewing skills
   c. Working with partners and stakeholders
   d. Rapport building
   e. Working with interpreters

2. Case Work Specific Skills
   a. Understanding case management and essentials of being a Case Manager
   b. Case management standard operating procedures and guidelines
   c. Basic understanding of international refugee law, national immigration laws, UNHCR guidelines and processes, migration related processes, and other refugee issues
   d. Mitigating risks and handling crisis
   e. Time management and planning
   f. Ethics and minimum care standards
   g. Child protection and children's rights
   h. Child centric decision making
   i. Child development and issues related to UASC
   j. Dealing with trauma
   k. Data collection for monitoring and evaluation
   l. Working with survivors of torture and trauma
   m. Mental health first aid/working with clients at risk of self harm

3. Case Manager Personal Skills
   a. Self-care
   b. Boundaries and personal safeguards
   c. Being a leader
   d. Working in a team.

4. Personnel Self-care: Debriefing and Reflecting on Practice

Self-care is an important aspect of the work. It ensures that personnel are able to manage stressors on the job and have a clear mind to make effective decisions. As Case Managers will be faced with clients who have experienced some form of trauma or exploitation, it is recommended that organizations put in place a self-care and debriefing process to avoid the occurrence of burnout and to be able to effectively manage Case Manager capacity.

It is also important that the Case Supervisor and Project Director are able to identify signs of burnout and the inability to cope among Case Managers. On identification of these signs, strategies to mitigate these problems should be put in place - including changing a Case Manager's role in the interim, giving opportunities for a break from work for rest or leisure, and getting external mental health assistance, where necessary.

It is recommended that an independent third party facilitate a self-care or debriefing process with individual Case Managers and Case Managers in a group on a bi-monthly basis and/or after a case discussion of a critical incident. Debriefing should also happen during monthly team review meetings with the Case Supervisor and Project Director. The debriefing exercise will provide Case Managers the avenue to share learned experiences, evaluate critical incidents and develop strategies accordingly, and to reflect on emotions, personal development or personal stressors. Suggested debriefing frameworks are provided in **Annex 4**.

5. Storage of Information

Case Managers are required to document all interviews, home visits, emails and/or telephone conversations with clients where relevant in the case management process. All information in relevant forms and assessments, including intake reports or assessments, needs assessments, progress reports, referral reports, intervention plans, monitoring and evaluation forms, consent and confidentiality forms, amongst others, should be stored in soft and hard copy formats.

All forms, assessments or reports should have the following information:
- Full date
- Full case number and status of the case
- Name of the report
- Case Manager and Case Supervisor's name

Hard copies of these forms, assessments or reports must be stored in a client folder that is kept in the office at all times in a secured or locked cabinet, and only accessible to authorized individuals. All client folders must be labelled with the case category, year of admission, assigned client number, and the status of the case. Cases may be categorized as per the following:

a. Open Case (O)– for active clients still within contact and currently accessing services
b. Inactive Case (IA) – for instances where contact is lost with the client due to some unexplainable circumstances. In these instances, the case may become active once communication or contact is resumed, or closed once the child is no longer in the country or remains untraceable.
c. Aged-out Case (on a transition plan) (AO) - cases when the child turns 18 and is on a transition plan. Transition cases will be automatically closed six months later, unless otherwise agreed.
d. Closed Case (C) – upon case termination under specified circumstances, depending on the case at hand, usually upon a durable solution being achieved.

All softcopies of the forms, assessments or reports must contain a header with the case number and the status of the case. All softcopies must be stored securely on a cloud server, accessible only to authorised individuals. All confidential documents must be stored with a password protect known only to the Case Manager and Case Supervisor. Photographs may be stored as softcopies on the cloud server and identifying photos must be password protected. Where there are hardcopies of pictures, these must be stored in the respective client folders.

6. Accountability and Continuous Improvement

Monitoring and Evaluation

To ensure accountability, the programme should have in place a monitoring and evaluation framework to ensure goals and outcomes are being met. A suggested internal monitoring and evaluation framework of the programme has been developed. The framework evaluates the programme across case management goals (see **Annex 43**).

Reporting from the monitoring and evaluation should be provided to funders, board members and other implementing agencies, where necessary. Reporting may be provided in quarterly, half-yearly and/or yearly reports.

Continuous Improvement

It is important that time and effort be invested in continuous improvement of programme procedures and processes. This is done through the periodic review and revision of procedures and forms contained in this Manual, and review of staff performance and any other relevant documentation conducted regularly. Continuous review will ensure procedures and processes are in line with the current needs and the country context.

Complaints Mechanism

In a dynamic environment working with marginalized populations, grievances and the occurrence of misconduct by Case Managers may arise. All staff, volunteers and clients will be able to access a confidential complaints mechanism to raise any allegations or observations of misconduct, violation of child protection polices, or dissatisfaction of services by the organization or its staff.

In general, all allegations, grievances and problems will be treated confidentially. Furthermore, all allegations, grievances and problems will be investigated fairly and without judgment or prejudice to all parties involved.

a) External grievance process

Complaints by clients, partners or implementing agencies: All clients, partners or implementing agencies must make a formal complaint of any staff misconduct or service provision via a formal complaint form (**Annex 5**) and can submit this confidentially to the Case Supervisor, Project Director or Administrator of the organization. The complainant may be called for further information during the investigation process. The Case Supervisor or Project Director will undertake investigations impartially and will communicate in writing on the follow up actions within 15 days of receiving the complaint. Requests may be made to change Case Managers or for cessation of services.

b) Internal grievance process

Internal grievances may arise under two main circumstances:

Interpersonal conflict among Case Managers: It is recommended that for cases of dissatisfaction or interpersonal conflicts between staff, attempts are first made to resolve the problem through informal means and with open communication. When this fails, the staff must make a formal complaint, (using **Annex 5**) which must be submitted to the Case Supervisor. The Case Supervisor must undertake all relevant investigation, which may include a request for further information from the complainant. All parties will be given the opportunity to refute any allegations. The Case Supervisor must carry out all investigations and respond in writing with a solution or course of action within 15 days of receiving the complaint, unless otherwise stated.

Serious violation of agency policies, ethical standards or misconduct: All staff members must formally report incidents of serious violation of policies and ethical standards to the Project Director as soon as possible (using **Annex 5**). The Project Director will undertake all relevant investigation, which may include a request for further information from the complainant. Investigations will refer to the agency Child Protection Policy in **Annex 1**. All parties will be given the opportunity to refute any allegations. The Project Director must carry out all investigations and respond in writing with a solution or course of action within 15 days of receiving the complaint, unless otherwise stated.

Where misconduct by staff is found to be criminal or in serious breach of organization's policies, an independent investigation should be undertaken by an independent expert, and/or law enforcement agencies, where necessary. All parties will be given reasonable opportunity to challenge any findings from this investigation and will be briefed on any legal and administrative action that will be taken.

D. WORKING WITH STAKEHOLDERS

1. Working with Children

Particular care needs to be taken when working with children. It is important to ensure that Case Managers have the right skills sets to work with the evolving maturity and development of a child. The uniqueness of each child must be appreciated and the case management process must be in line with the level of maturity and understanding of the child.

Interviewing children, particularly those who have experienced some form of trauma, also requires a certain level of skill. In the effort to extract comprehensive information, Case Managers run the risk of re-traumatizing a child with extensive questioning. Inappropriate questioning can also break the rapport and trust between a client and a Case Manager. In general, Case Managers must always practice the principle of "do no harm" by ensuring that a child is not further re-traumatized or feels humiliated. Create a safe, open environment for a child and avoid questions that are judgmental, overly intrusive and insensitive. Give the child the option of not answering particular questions or ending the interview should they feel uncomfortable. **Annex 6** provides a non-exhaustive guide for Case Managers when interviewing children.

2. Working with Interpreters

An Interpreter is usually needed from the start of the case management process. Arrangements for an interpreter may be made with the relevant service providers or referral agencies based on the needs of your client. Please ensure that all interpreters are briefed on the case management process, child protection policy and confidentiality policy of the organization. All interpreters must sign the child protection policy and confidentiality policy before providing any interpretation services. It is recommended that trained interpreters are used; however, this may be limited based on the current lack of training opportunities in the country. To capture accurate information, interpreters must be briefed on the guidelines for an interpreter and, particularly, be reminded to translate information as it is without paraphrasing or inferring meaning to the information. Suitable remuneration allowances should be determined, based on the country practices. A suggested guide to interviewing and working with interpreters is provided in **Annex 7**.

3. Working with Partners

As part of the case management and community placement process, you will be required to develop a working relationship with various partners such as government agencies, other NGO service providers, UNHCR, community based organizations, and other individuals. Engagement with partners is important to address the various needs of your client. It is important to be aware of the organizational requirements of partners and the need to remain client centric. Any engagement with partners must be done without compromising the needs and the best interest of the child.

THE CASE MANAGEMENT PROCESS

Foster Care Community Placement
- Screening
- Intake
- Training
- Selection
- Matching
- Orientation
- Care Planning
- Preparation for Exit
- Exit and Follow Up

Matching conducted if a child is assessed to be placed with a foster family

To be conducted with foster parents if a child is placed with a foster family

Collaboration between foster parents and case managers to implement the care plan by providing feedback, supporting the care plan and preparing the UASC for exit

Case Management #CM12345
- Referral
- Screening
- Rapport Building and Intake
- Assessment
- Rapport Building and Care Planning
- Implementation of Care Plan
- Monitoring and Reassessment
- Termination and Case Resolution
- Transition Phase for Aged Out UASC

To be conducted with foster parents if a child is placed with a foster family

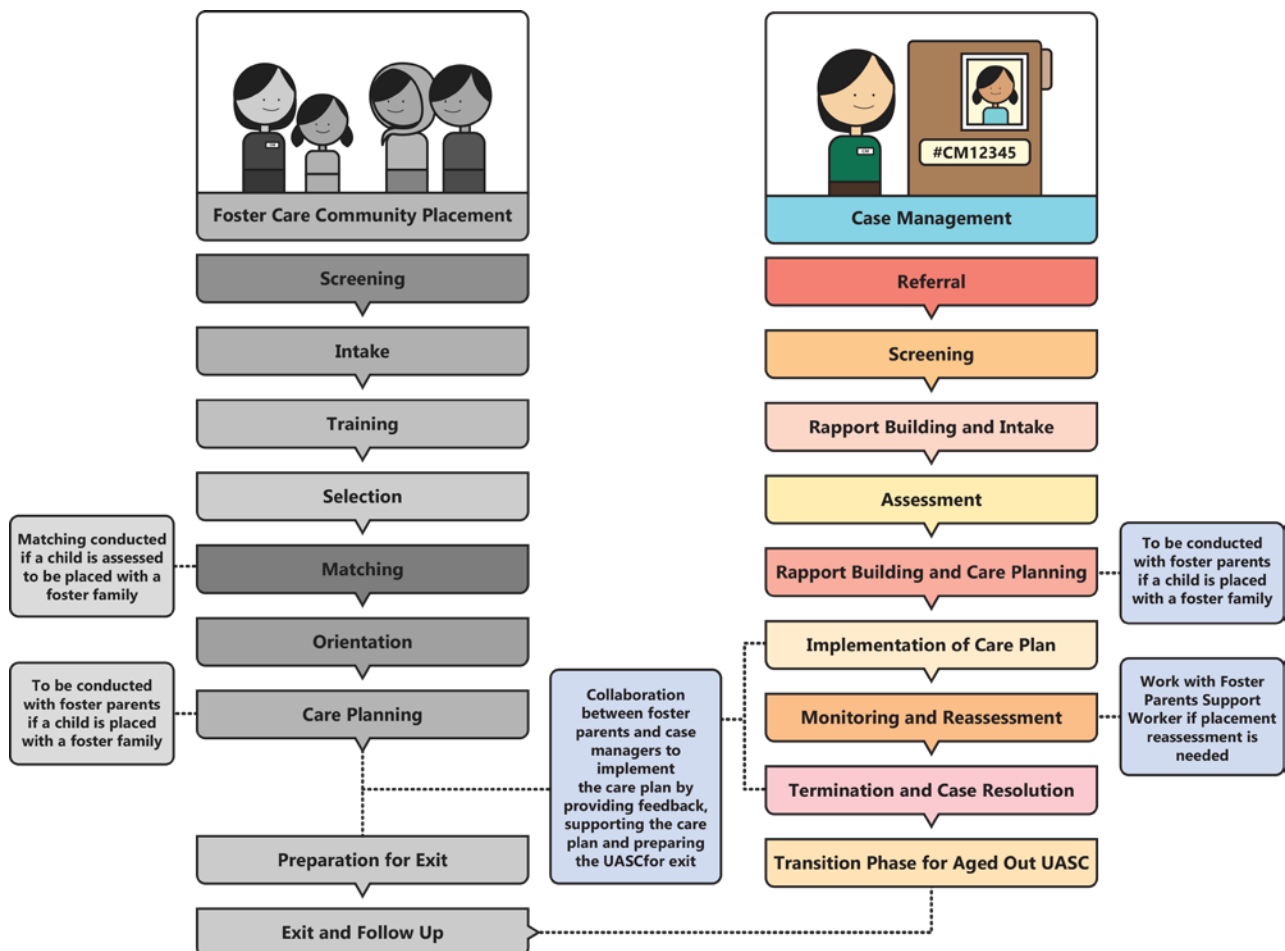Work with Foster Parents Support Worker if placement reassessment is needed

Figure 5 Flowchart highlighting the case management process and point of collaboration with other stakeholders such as the foster parents.

Individual Case Flowchart

Phase 1: Referral Process

Referral of UASC from UNHCR, NGOs, CBOs, individuals in the community as well as self-referrals from the UASC

Phase 2: Screening Process

Screening for programme requirements and request for identity documents

Phase 3: Rapport Building and Intake Process

Rapport building– first meeting with the child to build trust and respect

Phase 4: Assessment Process

Internal Case Conference to decide on admission, support and placement

Phase 5: Rapport Building and Care Planning Process

Rapport building – first meeting if the Case Manager did not carry out the intake interview

Developing the SMART goals care plan with the child

Intake process to identify child's needs, risks and protective factors

Needs

Risk Factors

Protective Factors

SMART

Phase 6: Implementation of Care Plan/Intervention Phase

Implementing the care plan - interventions with referrals (where relevant) and the coordination of services with relevant service providers to achieve safety, stability and permanency, and well-being goals

Phase 7: Monitoring and Reassessment Process

Care Plan #CM12345

Case manager to monitor and conduct regular reassessments and monthly internal Case Management meetings to review progress of the care plan

Phase 8: Termination and Case Resolution Process

Case resolution achieved either through a durable solution or a minor aging out of the programme. Other forms of termination to be noted.
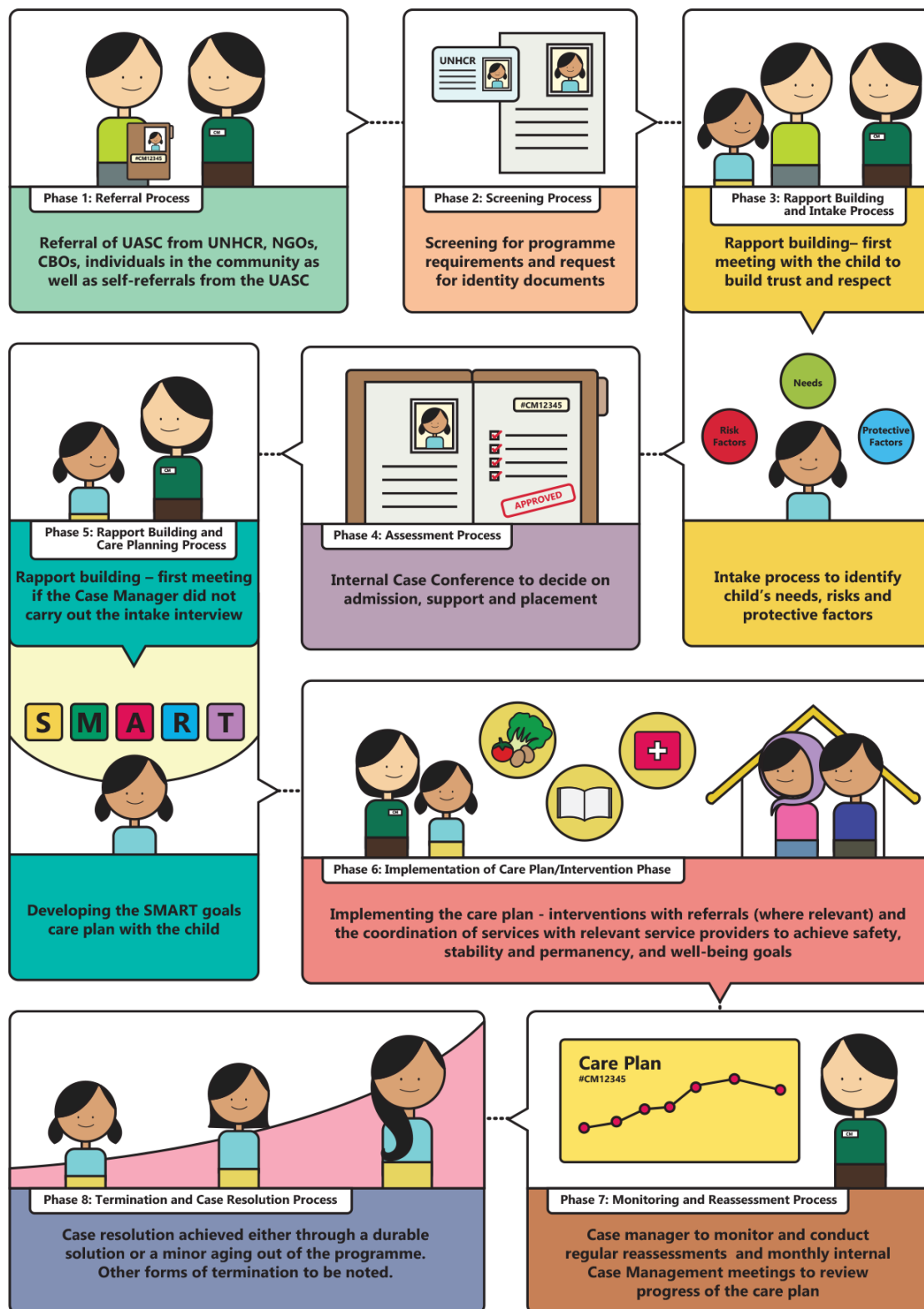
Figure 6 The case management processes in a snapshot for an individual child.

E. THE CASE MANAGEMENT PROCESS

Phase 1: Referral Process

The first phase of case management is the initial referral process.

> **Referrals are made by non-governmental agencies, community based organizations and individuals, and/or UN agencies. All documentation and referral forms are completed accordingly. Case Managers respond and acknowledge receipt of a referral within three working days. A first meeting with the client should be scheduled within seven to 14 days of the referral.**

A suggested referral process is listed below:

1. Referrals may be made by non-governmental organizations, the UNHCR, community based organizations or individuals.

2. When a case is referred for case management, ensure the referral agency accurately fills in the referral form in **Annex 8** with relevant documentation. The completed form may be emailed to the relevant persons listed on the form (at the top section).

3. The Case Supervisor must respond and acknowledge receipt of the referral within three working days.

4. If a child self-refers, ensure collection of the following information:
   a) Name
   b) Age or date of birth
   c) Country of origin
   d) Whether unaccompanied or separated
   e) Telephone number
   f) Languages spoken
   g) Exact location or where they are staying
   h) With whom are they staying (family, single men, employer)
   i) Copies of relevant identity and medical documents

5. The Case Supervisor will screen and make a preliminary assessment as to whether the case falls within the scope of the case management process based on the information in the form.

6. However, if upon referral the child is deemed to be in immediate danger, the Case Supervisor must contact relevant agencies or organizations for the child to be placed in a temporary shelter, while waiting for full screening or an intake interview to be conducted.

Phase 2: Screening Process

Following a referral, a screening process is undertaken to determine if a referral fits the relevant scope of the programme.

> **Referrals are screened based on programme requirements. Priorities determined based on country context and organizational capacity. Case Supervisor will assign a Case Manager to conduct the intake interview. If the child's identity cannot be clearly identified, the benefit of doubt is given to the child**

A suggested screening process is as follows:

1. The Case Supervisor who receives the referral form will make a preliminary assessment as to whether the case falls within the scope of the organization's programme based on the information in the referral form.

2. Cases may be screened along the below criteria using the screening template in **Annex 9a**:
   a) Age in documentation – whether above or below 18 years
   b) Documentation status – whether undocumented or has some form of valid document that prevents arrest and detention
   c) Safety in the community placement or housing – whether stable or unstable care environment
   d) Location – whether within the area of the organization's work
   e) Any other known vulnerabilities – whether he/she has experienced sexual or gender based violence (SGBV), a survivor of violence and/or torture (SVT), or has mental health issues or disabilities.

3. The screening priority measurement below is based on the country context, community needs, and organizational capacity and resource. This priority scale should be adapted to fit the relevant organization and country context.

Priority	Description	Action taken
Screened out	above 18 in official documents, documented, and in safe housing	Client or referral agency informed that no further action will be undertaken until more documents are provided
Keep in View intake	above 18 in official documents, undocumented and in unsafe housing	Case Supervisor refers client for housing intervention pending further documentation
Normal priority	below 18, documented, in safe housing	Case Supervisor schedules intake within three weeks of referral date
Urgent priority	below 18, undocumented, in safe housing; or below 18, documented, in unsafe housing	Case Supervisor schedules intake within seven days of the referral date with relevant housing intervention where necessary
Highest urgent priority	below 18, undocumented, in unsafe housing	Case Supervisor schedules intake within three days of referral date
Emergency priority	below 18, undocumented, and at risk of abuse or exploitation	Case Supervisor does an immediate intervention to ensure the safety of the child pending a full intake interview

4. If a referral is assessed as being within the scope of the programme, the Case Supervisor will assign a Case Manager to conduct the intake interview to assess the vulnerabilities and immediate needs of the child.

5. If the child's identity cannot be clearly identified (e.g. lack of documentation to determine age or vulnerabilities), the benefit of doubt is given to the child, and the Case Manager proceeds to conduct an intake interview to obtain further information.

6. In some circumstances, screening may also be done in detention centres. Depending on the capacity of the organization, the screening may prioritize the release of children based on the vulnerabilities present and feasibility of a case resolution or readily available community placement. A suggested screening tool is provided in **Annex 9b**.

ANNEX 9B: UASC ARREST AND DETENTION SCREENING TOOL

UASC understands purpose of screening	☐ Yes ☐ No
UASC consents to screening process	☐ Yes ☐ No
UASC consents to tracing activities where needed	☐ Yes ☐ No
UASC consents to storing and sharing of information with other organizations involved in the screening and/or release process	☐ Yes ☐ No

A. PERSONAL BIODATA	
Name (all aliases):	Sex: ☐ MALE ☐ FEMALE
Date of birth, year of birth or an approximate age:	Place of birth:
Country of origin:	Ethnicity:
Religion:	Languages spoken:
Legal status:	Documents the UASC possesses, if any:
Date of arrival in Malaysia:	Reason of entry in Malaysia
Previous address:	Previous telephone no.:

B. DETENTION INFORMATION	
Current location:	Place of arrest:
Date of placement in current location:	Date of arrest:
Charges:	Status of processing:
Actions undertaken by the authorities for case resolution (e.g., contacting embassies, UNHCR, etc.):	

C. NEXT OF KIN INFORMATION	
Name of father:	
Legal status (if in Malaysia):	Telephone no.:
Current location and other relevant details (e.g. body number if detained):	

Name of mother:	
Legal status (if in Malaysia):	Telephone no.:
Current location and other relevant details (e.g. body number if detained):	

Name of sibling(s) in Malaysia (please list all):	
Legal status:	Telephone no. of each person listed:
Current location and other relevant details (e.g. body number if detained):	

Name of sibling(s) outside of Malaysia:	
Current location and other relevant details (e.g. body number if detained):	Telephone no. of each person listed:

Name of extended relatives in Malaysia (please list all):	
Legal status:	Relationship to child:
Current location and other relevant details (e.g. body number if detained):	Telephone no. of each person listed:

Name of primary caregiver in Malaysia:	
Legal status (if in Malaysia):	Telephone no.:
Current location and other relevant details (e.g. body number if detained):	

Phase 3: Rapport Building and Intake Process

1. Rapport Building Process – The first meeting

> **Time is invested in engaging and building rapport with clients. A supportive and safe environment is created for the client. The surrounding environment should be suitable for interviews, and the client's non-verbal cues and apprehension noted. Multiple visits should be scheduled, particularly for those who have experienced some trauma or abuse.**

The client-case manager relationship is a dynamic relationship based on mutual trust and respect. Rapport building is an ongoing process for building trust, establishing common ground, demonstrating empathy and understanding, and opening up channels of communication throughout the lifecycle of a case. It is important for Case Managers to invest time in engaging and building rapport with their clients. Rapport building starts at the first meeting with the child. The following are some suggested methods to build rapport and some important things to keep in mind when you first engage with a child:

1. Take time to create a supportive, safe and welcoming environment when you first meet the child.

2. If you are just building rapport, do not collect any specific information at this stage, as the consent and confidentiality process has not been undertaken.

3. Conversation topics during this phase may include an introduction to the Case Manager and the organization, general conversation about how the child is doing or his/her interests, answering questions or concerns of the child.

SOME KEY QUESTIONS AND THINGS TO PAY ATTENTION TO:

a. Child's surrounding environment - Is it suitable for future assessments or interviews?
b. Non-verbal behaviour –How is the child responding to you?
c. Interaction with people closest to the child (guardian, community member, referring agency) – Will rapport improve if an individual close to the child is present for the subsequent home visits?

4. Acknowledge the child's anxiety and apprehension and try and create a safe, comfortable and open environment.

5. Be present and listen to the child as he or she speaks.

6. Acknowledge any biases you or the child may have towards each other – for example, gender biases where a female child might consider herself not as important to be heard as for a male child.

7. Acknowledge any cultural differences or expectations that may impede communication and rapport building – for example, cultural differences in body language and tone.

8. Manage expectations in your role while making the child feel comfortable and engaged in the process.

9. For those children who have experienced trauma or abuse, multiple visits may be needed as part of this rapport building process. Make a note of your observations and consult your Case Supervisor to decide if follow up visits are needed to build trust and rapport. Hardcopies of these notes must be filed in the respective client folders for future reference.

2. Intake Process

> **Interviews are scheduled based on urgency levels. Purpose of the visit, organization services and your role as the Case Manager is explained to the client. A client's needs, strengths, risks, and challenges are identified during this process. All information is captured accurately, comprehensively and in first person language. Information is stored and regarded confidential.**

In the intake process, the interviewer will carry out an interview to identify a client's needs, issues, strengths, challenges, and risks that will be useful for the assessment process. It is important that the interviewer captures all the information accurately and comprehensively to support the decision making and care planning process. Where necessary, the intake process may be carried out in the presence of persons that the child can trust.

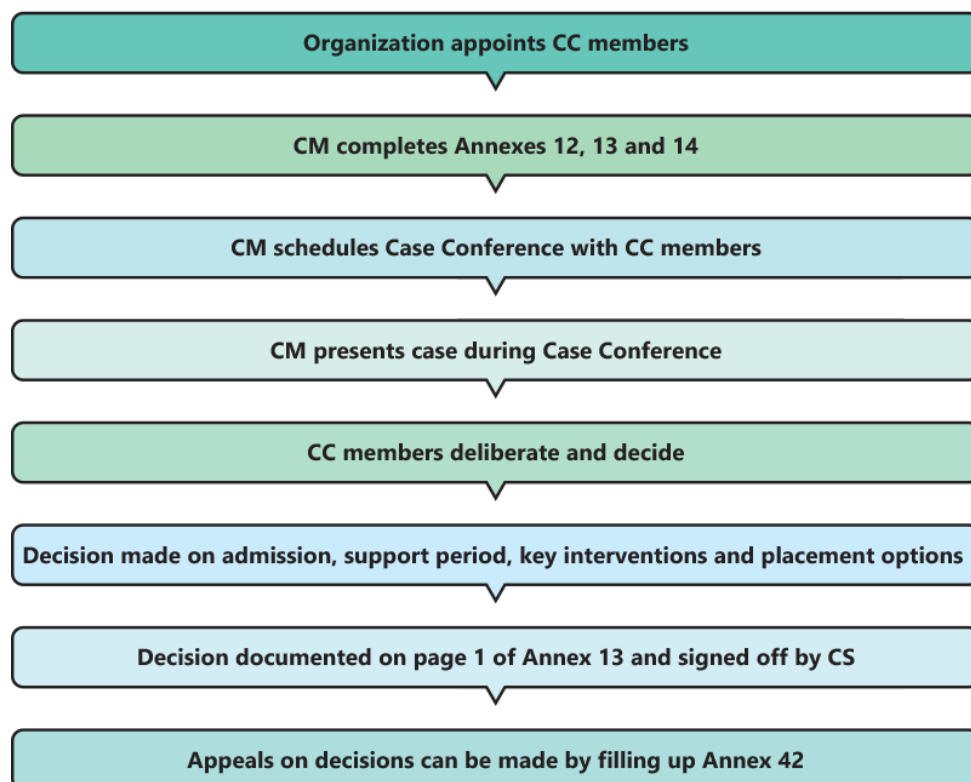The following is a suggested process framework:

1. Once a child's case has been assigned to a Case Manager, the Case Manager should arrange for an intake interview based on the priority timelines under Phase 2: screening process.

2. Arrangements to decide on the date, time and place for the intake interview should be made depending on the circumstances of the case: either by contacting the agency or the person who made the referral, or the child, through an interpreter.

3. Make arrangements for a suitable interpreter to be present during the intake interview. Ensure the venue is conducive and has adequate privacy.

4. At the start of the interview, the Case Manager should do the following (as provided for in **Annex 10**):
   a) Explain the purpose of the visit or interview, the organization's scope, and the general interview process.
   b) Explain the role of the Case Manager and the organizational decision-making process. Make sure you manage expectations about decision-making timelines and limitations in the organizations influencing the migration/refugee process.
   c) Address confidentiality concerns by highlighting how information will be shared and stored.
   d) Explain the right for a child not to answer questions he/she is not comfortable with and allow the child to ask any questions he or she may have.

5. If the child seems nervous or uncomfortable, try to build rapport and make the child feel relaxed by attending to his or her immediate needs, such as offering a drink or a snack. Start by talking about positive or neutral topics, such as favourite things or interests.

6. Ask the child for consent before proceeding with the interview. If the child does not consent for whatever reason, the interviewer will have to end the interview and reschedule once the child is ready to be interviewed.

7. Use the Client Needs and Risks Intake Form (**Annex 11**) as a guide in conducting the interview. Fill in all the required information as you go along. Information on needs can be collected across pertinent life areas including: daily functioning and welfare needs, legal, educational, health, and psychosocial needs, the existence of any abuse or exploitation, and the child's interests and life goals. The form provides an understanding of the needs, risks, and strengths of the client.

8. It is important for the Case Manager to pay attention to both verbal and non-verbal responses, taking into consideration the cultural norms and barriers in communication, as well as observing the surrounding circumstances of the child. Ensure that the child has adequate opportunity to narrate his or her story or communicate his or her needs.

9. The Client Needs and Risks Intake Form provide guiding questions to be used at your discretion, depending on the openness of the child and the level at which trust and rapport has been built. Where the child is not comfortable responding, move on to the next question taking note of the non-verbal cues.

10. Any urgent need disclosed during the intake interview must be addressed by the end of the interview. For example, if safety in housing is a concern the Case Manager may need to contact relevant agencies or organizations for a child at high risk to be placed in a temporary shelter, if necessary.

11. The Case Manager may also need to schedule and conduct interviews with other persons in the child's life to obtain additional or corroborative information to note down in the Client Needs and Risks Intake Form.

12. Once the interview is completed, thank the child for his or her time and for sharing his or her story with you. Manage expectations that a decision on admission into the Programme will take some time, and inform the child that you will be contacting him or her after a decision has been made.

13. Hardcopies of all intake forms and notes must be stored in the relevant client folders in the organization's office, and scanned copies of these forms must be stored on the cloud server. Information from these documents should be kept confidential.

Phase 4: Assessment Process

> **Information gathered during the intake process is used by the Case Committee to assess a case. Decisions are made based on weighing the needs, risks, and protective factors of a case in the best interest of a child. Goals are also suggested to assist the Case Managers with the Care Planning phase. This phase should be completed within four weeks of the intake.**

The assessment process involves the Case Committee making an assessment on the case based on the information gathered during the intake phase. The Case Committee will engage in a rigorous and detailed analysis of information to determine support that will be in the best interest of the child. Decisions made during this phase will be used to effect phase 5 of the case management process. The following is a suggested process framework:

Organization appoints CC members

CM completes Annexes 12, 13 and 14

CM schedules Case Conference with CC members

CM presents case during Case Conference

CC members deliberate and decide

Decision made on admission, support period, key interventions and placement options

Decision documented on page 1 of Annex 13 and signed off by CS

Appeals on decisions can be made by filling up Annex 42

'CC' Case Committee; 'CM' Case Manager; 'CS' Case Supervisor

Figure 7 Recommended steps for an assessment process

1. The organization will appoint members to be in the Case Committee, who will assess cases presented for admission and review. Members of the Case Committee should, at the very minimum, include the Case Managers, Case Supervisor, Project Director, and an independent advisor.

2. Prior to the Case Conference being scheduled, the Case Manager is expected to do the following:
   a) **Complete the Heightened Risk Rating Form (Annex 12)** to determine the child's current level of risk. Risk assessment should include both risk and protective factors for the child. Areas of potential risk include future housing, possible caregiver relationship, legal status, past abuse or exploitation, and any physical or mental health concerns, amongst others.

b) Complete the **Programme Admission Form (Annex 13)** based on information gathered during the intake phase and noted on the heightened risk rating form.

c) Complete the **Child Trauma Screening Questionnaire (Annex 14)**. The 10-item self-report screening tool may be used to identify children at risk of developing post-traumatic stress following a particularly traumatic event, such as immigration detention, flight from the country of origin, recent persecution in the country of origin, etc. The tool will assist Case Managers in developing the necessary intervention plan to address the risk of post-traumatic stress.

3. Once documentation is completed, the Case Manager will schedule for a Case Conference with the Case Committee. The completed documentation will be given to the members of the Case Committee before the scheduled Case Conference.

4. During the Case Conference, the Case Manager will present the case along with relevant recommendations. The Case Committee will thoroughly deliberate, weighing organization capacity and resources, and the risk and protective factors for the child.

5. A decision is then made as to whether the child should be provided with case management support, the time period for support, and key interventions to be carried out. The Case Committee also decides on a suitable community placement option for the child (i.e. if he or she should be placed in foster care or provided with other forms of intervention).

> In some cases, a child may not be suited for the full case management programme or may be screened out because he/she may not fit the programme criteria.
>
> In such cases, the organization should be open to solving specific needs of a child, where possible. Specific and time-bound interventions may still be carried out to ensure, at the very least, that the child is safe and not at risk of arrest and detention.
>
> Examples where case management may not be appropriate include when the child is above 17 years old, when age cannot be gauged properly, when a child is unwilling to voluntarily cooperate with the programme requirements or when a child is a separated minor in safe care arrangements.

6. Decisions made will be documented on page 1 of the **Programme Admission Form (Annex 13)** and signed off by the Case Supervisor. This document will be used to assist the Case Managers during the care planning phase. This document will also beused when reviewing the case during a monthly case meeting.

7. Decisions must be made on a case by case basis after considering the child's risk and protective factors. Clear justification for decisions made and the timelines for interventions and next steps must be written down to guide Case Managers.

8. The child has the option of appealing a decision by the Case Committee by filling in the **Admission Appeal Form (Annex 42)**, which will be submitted to an independent assessor appointed by the organization. Any decision made by the assessor is final.

9. Hardcopies of all assessment forms must be stored in the relevant client folders in the organization's office, and scanned copies of these forms must be stored on the cloud server. Information from these assessments should be kept confidential.

10. The assessment phase should be completed within four weeks of the intake for non-emergency cases.

Phase 5: Rapport Building and Care Planning

> **Rapport building is initiated if it is the first meeting. Case Managers continue to engage and build rapport with the client throughout the life cycle of the case. Care planning is carried out with client input, and where relevant, with input of foster parents. Consent should be obtained for participation in the programme. An individualized care plan with the necessary referrals should be developed within 14 days of the completion of Phase 4. Goals, strategies, outcomes and timeframes are Specific, Measurable, Achievable, Realistic, and Time bound (SMART).**

1. Rapport Building

If the assigned Case Manager did not conduct the intake interview, the first point of contact with the child will be during this Phase. Rapport building will therefore begin at this phase. Suggested methods to build rapport discussed in Phase 3 will similarly apply here.

Rapport building will also continue throughout the lifecycle of the case. Taking time to maintain rapport is important to ensure a child's continuous engagement and compliance in the case management process. If there is no rapport, it can result in the child absconding or disappearing, a lack of trust between the Case Manager and the client, non-compliance with programme requirements, and challenges in meeting care plan goals. Though not an exhaustive list, below are suggested methods to continue to build rapport and engagement with the client:

1. Continue to create a trusting environment and relationship with your client. Ways to do so would be to respect confidentiality and only share information with others on a needs basis and as agreed by your client.

2. Respond to queries or messages from the child in a prompt manner. A response to say you will get back to him or her as soon as possible would show that you place importance on his or her needs.

3. Keep scheduled appointments and arrive on time for appointments with the child as this shows you are respecting his or her needs and time. If you are unable to attend an appointment because of an emergency, apologize and inform the child promptly.

4. Respond to emergencies as soon as possible, and when doing so, be empathetic and mindful of the child's fears and concerns.

5. Be empathetic and present for the child when he/she is going through difficult appointments or challenges in life.

6. Listen to the child to keep him/her engaged throughout the process.

7. Avoid making decisions for the child, but instead, engage in a decision making process by jointly weighing the pros and cons, and empowering him or her to decide for himself/herself. This will, of course, be dependent on the age and maturity of the child.

8. Keep yourself updated and remember important appointments (such as migration related appointments), and follow up with the child on the outcome of these appointments.

9. Regularly conduct checks with the child to maintain contact. This helps the child know that there is someone looking out for him or her. When you are away, make arrangements for other Case Managers or volunteers to check-in with the child.

10. Finally, extend wishes to the child during religious, cultural days, or birthdays to show that you are aware of his or her beliefs and practices and that he/she is important.

2. Care Planning

Care Planning is a multifaceted process, which ties in the relevant goals and needs of the client with a holistic intervention plan. Care plans are client centred and may be developed after several meetings or visits with the child, and in close discussion with caregivers, the Case Supervisor and other Case Managers.
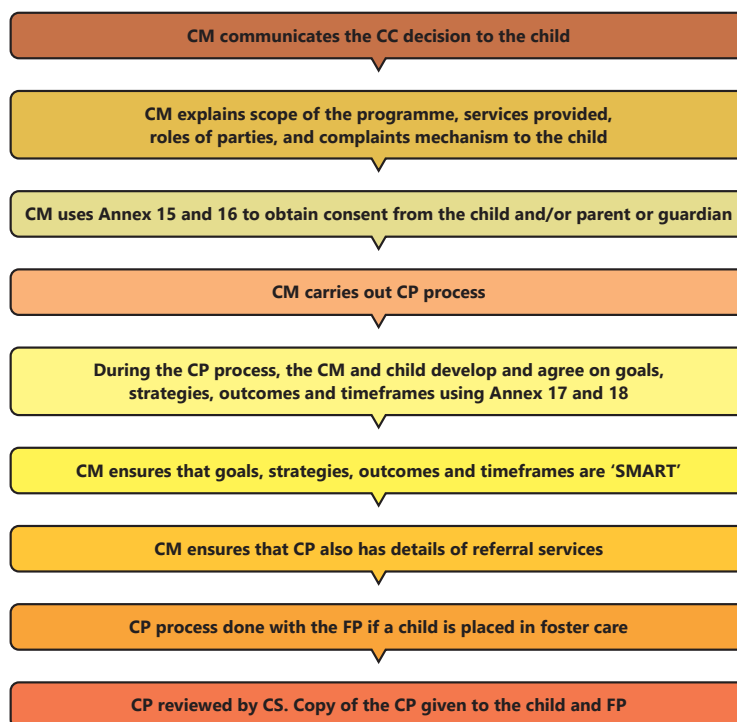
The care plan will include:

1. Identified needs or risks.
2. Specific client goals to address these needs or risks.
3. Strategies or an action plan to achieve these goals.
4. Agreed timeframes to undertake the action plan.
5. Clearly assigned tasks or referral processes based on the timeframes.
6. Clearly specified outcomes and results.

Regular reassessments should be built into the care plan to adapt to changing circumstances and to track progress of the goal attainments.

> If a child is placed in a foster care arrangement, the care plan should be developed with the foster parents. Foster parents play a crucial role in the implementation of the care plan and ensuring the case management goals are met. It is therefore important for foster parents to know their roles in the care plan and participate actively in this process of developing the care plan with the Case Manager and the child.

A suggested process in the care planning phase is as follows:

CM communicates the CC decision to the child

CM explains scope of the programme, services provided, roles of parties, and complaints mechanism to the child

CM uses Annex 15 and 16 to obtain consent from the child and/or parent or guardian

CM carries out CP process

During the CP process, the CM and child develop and agree on goals, strategies, outcomes and timeframes using Annex 17 and 18

CM ensures that goals, strategies, outcomes and timeframes are 'SMART'

CM ensures that CP also has details of referral services

CP process done with the FP if a child is placed in foster care

CP reviewed by CS. Copy of the CP given to the child and FP

'CM' Case Manager; 'CP' Care plan; 'FP' Foster Parents; 'CC' Case Conference; 'CS' Case Supervisor

Figure 8 Recommended steps for the care planning process

1. Case Managers will schedule a meeting with the client to inform him/her of the organization's decision and will obtain consent for participation in the programme.

2. As the client is a minor, consent will need to be obtained from the parent, guardian or caregiver, where possible, and from the child. A sample of the relevant consent forms are included in **Annex 15 and Annex 16.**

3. During this phase, Case Managers must:
   (a) Explain the decision, and respond to any questions a child may have with regards to the decision
   (b) Clearly explain the scope of the programme or services that are to be provided, based on the decision made by the organization.
   (c) Explain the role of the child and Case Manager throughout the process.
   (d) Provide information on the complaints mechanism, should the child be unhappy with the services provided by the Case Manager.

4. A hardcopy information pack with detailed information on the above processes should be provided to the child.

5. Hardcopies of consent forms must be stored in the relevant client folders in the organization's office. Scanned copies of these forms must be stored on the cloud server.

6. Once consent has been obtained, and the child fully understands his or her rights and the case management process, the care planning process may be initiated. The Case Manager will engage with the child to develop and agree on goals, strategies, outcomes and timeframes. As a Case Manager, ensure that goals, strategies, outcomes and timeframes are **Specific, Measurable, Achievable, Realistic, and Time bound**. This exercise will be carried out using the Full Client Individualized Care Plan Template in **Annex 17 and 18**.

7. The Care Plan Template is to be cooperatively filled by the Case Manager and the client with both parties agreeing on the goals, strategies, outcomes, timelines and responsibilities. Each goal and action will be specific to the child. Once the goals are agreed on, they will be written down and a copy of this form will be given to the child.

8. The Care Plan must also provide all relevant details of referral services that will need to be utilized by the child, and list persons responsible for engaging these referral service providers. The Care Plan will also be adapted and changed in Phase 6 and 7, depending on the child's progress and the relevant monitoring and reassessments exercises.

9. If the child has been placed with a foster family, this care planning exercise is undertaken with the foster parents. The Case Manager will work with the foster parents and the child to design and implement a care plan for the placement. A copy of the care plan will also be given to the foster parents.

10. Once the care plan has been developed, it must be reviewed by the Supervisor within two weeks. The supervisor may provide input on the accuracy and suitability of the care plan.

11. All information obtained here will be stored in a similarly secure manner as stated above, in hard and soft copy formats.

12. The individualized care plan should ideally be completed within 14 days[6] of the completion of Phase 4 and will continue to be reassessed or updated throughout Phase 6 and 7.

13. A sample completed Care Plan is provided in **Annex 19**.

ANNEX 19: SAMPLE GOALS DEVELOPMENT/CARE PLAN

	Planning			Implementation			
No.	Identified needs and risks	Identified goals	Expected outcomes	Action plan (include strategies and referrals)	Timelines	Responsibility (referrals, client, CM)	Completion (× or ✓)
1.	**Housing** - overcrowded - single men - no caregiver - cannot afford rent	To find safer housing with someone to look after him/her	Safe home environment and stability in placement	• Find a suitable foster family • Initiate the foster care placement process • Provide support to pay rent	Within the month	Case Manager Client Community leader Foster parents	
2.	**Legal status** - undocumented	To clarify legal status to be able to reside in Malaysia legally	Stability and safety from arrest and detention	• Referral to UNHCR for clarification of legal status • Referral to AAM for legal aid services	Immediately (within 3 days)	Referral – CM UNHCR AAM	
3.	**Physical health** - never had a health check	To obtain a proper health assessment	Good physical health	• Referral to a health NGO • Follow up on treatment where needed	Within the month	Referral – CM Health NGO	
4.	**Mental health** - SVT - misses family and home - feels guilty for leaving family	To be able to cope with feelings of being separated from the family	Better overall mental health – feel better about self	• Referral to MH NGO/ psychologist/ counsellor • Follow up on therapy where relevant	Within the month	Referral – CM MH NGO Client	
5.	**Education** - illiterate	To be able to read and write and speak English	Literate and able to converse with other people	• Referral to a school • Monitoring of attendance and lessons • Provision of writing and school materials	Within 2 weeks	Referral and school items -CM NGO school/ teachers Client	
6.	**Employmemt** - none at the moment	To develop skills to find a job once he/she ages out	Will be able to find a job on turning 18	• Exploring skills based learning options	Over the year	CM NGO partners	
7.	**Welfare needs – food, clothing, hygiene** - no food support - needs clothing and hygiene items	To be able to have nutritious food and adequate self-care items	Has adequate food, clothing and hygiene items	• Monthly food provision based on client's needs • Provision of hygiene items, once in two months • Provision of clothing after sponsorship is obtained	Food within 1 week Clothing and hygiene items - within the month	CM Donors Client	
8.	**Social support** - no friends - no one to talk to when feeling sad	To have a strong support system in the community	Cope better and able to do some fun activities	• Introduction to other minors in the programme and the community organization	Within the month	CM Client Other minors Community leader	
9.	**Family Tracing** - lost contact with family members after fleeing country	To be able to find family members	Cope better with current circumstances	• Referral to ICRC to initiate tracing process • Assistance with tracing activities where relevant	Within 3 months	Referral – CM ICRC Client	
10.	**Any other need** - no clear durable solution/case resolution	To be able to have a preparation/pathway to reach longer term solutions	More hope Longer term planning	• Reassessed after legal status clarified • Preparation with skills for adult living	Over the case cycle	Client CM Relevant partners	

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6   The following timeline is organizational specific based on current capacities and practices. Organizations should adapt timelines to fit their context and needs.

Phase 6: Implementation of the Care Plan or the Intervention Phase

An individualized care plan is initiated based on agreed strategies. The implementation of the plan and the referrals made are based on timelines in the care plan. Adjustments to the plan are made in consultation with the client.

Upon collectively planning the individualized care plan with the child using Annex 18, the intervention plan should now be initiated based on the agreed strategies and timelines.

When implementing the care plan, a Case Manager should:

1. Be proactive, action-and-solution-oriented, working with the child's strengths and empowering the child through a partnership process to attain goals and case resolution.

2. Implement care plan actions and strategies at the appropriate times to achieve goals.

3. Be flexible and able to adapt care plans or re-strategize based on internal and external variables.

If a child is placed in a foster care arrangement, the foster parents play a crucial role in the implementation of the care plan and ensuring the child has a safe and stabile home environment. Foster parents are also able to intervene during emergencies and are able to assist the Case Managers with interventions related to a child's well-being needs. Case Managers should however use their discretion on how much to involve the foster parents in the process based on capacity and resources.

4. Identify and explore creative options for referrals to achieve care plan actions.

5. Coordinate direct and indirect services for the child.

6. Collaborate and actively build relationships with referral agencies to increase efficacy in achieving care plan goals. Ensure that all relevant agencies are aware of each other's involvement in assisting the child through the process.

7. Maintain open communication with all stakeholders and ensure documentation of all communication and suitable sharing of information or reporting.

8. Ensure that the child understands and is always aware of any changes in the care plan or referral agencies.

It is recommended that timelines for the implementation of interventions and referrals be clearly identified in the care plan during Phase 5. Adjustments can be made to the care plan, when necessary, and in consultation with the client.

1. Coordination of Referrals with Service Providers

The main role of the Case Manager in the implementing phase is the coordination of services and referrals for the client to ensure that the child's needs are addressed. The Case Manager is expected to identify, communicate with, and follow up with all referral agencies on a regular basis.

A recommended process to coordinate referrals to service providers is as follows:

1. Identify the service provider based on the needs in the care plan and, also, the location of the child.

2. If a child is already accessing services with a service provider, check the services the child is provided to avoid the duplication of resources.

3. Once gaps and relevant service providers are identified, contact the service provider or individual by telephone or email to ascertain if the agency or individual is able to provide the relevant services for the child.

4. If the service provider has a referral form, complete the referral form. If the service provider does not have a referral form, use **Annex 20**.

5. Confirm appointment time and availability of an interpreter with the service provider by telephone or email.

6. During the first visit, accompany the child, providing any case notes or any other information that the child has consented to sharing to ensure that the service provider is able to provide the best care.

7. Following the first visit, keep in constant communication with the service provider and follow up on the child's progress.

8. Reports of this progress must be clearly documented. All documentation from the referral process must be stored in a similarly secure manner as stated before, in hard and soft copy formats.

2. Implementing Interventions

Interventions carried out will differ based on the needs of the child and goals of the case management. More detailed intervention plans may be developed for a specific need and further assessments may be needed. Potential needs of a child based on the case management goals that may require intervention include:
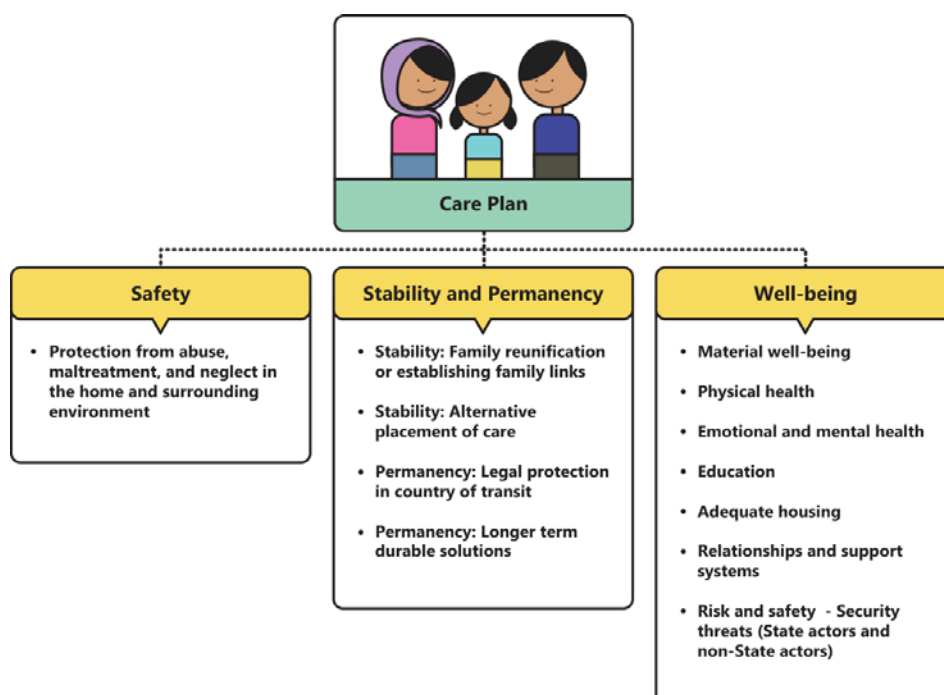

Figure 9 Case management goals and potential needs of a child as reflected in the care plan

A suggested process framework for each need is provided below.

Children in out-of-home care should be safe from abuse, maltreatment and neglect. Interviews, home visits, risk and safety assessments should be carried out with caregivers. Children must be placed in safer care arrangements within three months from admission into the programme. The safety plan should be developed with the caregiver and the child.

A child is in ***present danger*** when there is an immediate, significant, and clearly observable threat actively occurring in the present time. Danger or safety threats include any real or risk of physical, sexual, verbal maltreatment, abuse and neglect.[7]   A child is in **imminent danger** when there are conditions that are not actively occurring or clearly observable but are likely to cause serious harm to a child in the near future. For *imminent danger*, the harm is likely in the near future (not exceeding 60 days),[8] and if no intervention is carried out.

A core intervention process will therefore include ensuring that a child in out-of-home care is always safe from abuse, maltreatment and neglect.

The following suggested process should be carried out to determine if a child is safe in out-of-home care:

1.   Conduct regular monthly checks with the child to talk about the home environment and placement.

2.   Conduct interviews with the caregiver or persons in current placement to periodically assess the home safety situation.

3.   Home visits should be conducted on a monthly basis. During this time, observe the non-verbal interactions between the child and others in the home.

4.   A risk and safety assessment of out-of-home care must be conducted for every new placement.

5.   A best interest assessment should be conducted after 12 weeks[9] in a new placement.

If a child is deemed to be in present danger, the following is a suggested framework:

1.   Clearly document the threat or danger and determine if the child needs medical attention.

2.   If the child requires medical attention, immediately seek treatment at the Emergency Department of the nearest hospital.

3.   Find alternative places for the child to stay for the next 72 hours.[10]

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7   Adapted from UNHCR, Heightened Risk Identification Tool, version 2. Available at: http://www.unhcr.org/refworld/docid/4c46c6860.html.
8   Timelines adapted from UNHCR, Heightened Risk Identification Tool, version 2. Available at: http://www.unhcr.org/refworld/docid/4c46c6860.html.
9   Adapted from the Field Handbook for the implementation of UNHCR BID Guidelines. Available at: www.unhcr.org/50f6d27f9.pdf.
10   Timelines adapted from UNHCR, Heightened Risk Identification Tool, version 2. Available at: http://www.unhcr.org/refworld/docid/4c46c6860.html.

4.   Make arrangements for the child to move and remove the child from the unsafe environment to a temporary safe place pending full assessment.

5.   Call for a discussion with the Case Supervisor, or if time permits, call for an emergency Case Conference with the Case Committee.

6.   Following the case discussion, carry out relevant interventions which may include: making a police report or informing relevant authorities, finding new alternative care arrangements, and referring the child for further health interventions and psychological assistance.

If a child is deemed to be in imminent danger, the following is a suggested framework:

1.   Clearly document the threat as soon as possible.

2.   Discuss the case at a Case Conference. A decision should be made as to whether the child should be removed from the environment, for suitable recommendations for alternative placement, and for relevant timelines for the move.

3.   Identify and screen a suitable alternative care arrangement, preferably a foster care arrangement, within seven days[11] of the Case Conference.

4.   Ensure that the child's opinion is sought before any move to a care placement is made.

5.   Make arrangements for the child to move within 30 days of the first identification of the threat.

6.   Develop a safety plan with the child and new caregiver (**Annex 21**).

7.   Periodically follow up with home visits at this new placement to ensure that the child is adjusting well.

8.   Carry out any other relevant interventions which may include referring the child for further health interventions, psychological assistance, if necessary, and equipping the child with the necessary skills to protect him or herself.

Stability and Permanency: Family Reunification or Establishing Family Links

Work towards preserving the integrity of the family unit so long as this is in the best interest of the child. Provide relevant interventions to reunite a child with their parents or primary caregivers as soon as possible and in direct consultation with the child.

Children have a right not to be separated from their parents or family members. Following the principle of family unity, the primary responsibility of caring for a child lies with the child's parents, family, and community. Case Managers must work towards preserving the integrity of the family unit so long as this is in the best interest of the child. Family reunification and establishing family links must be done in direct consultation with the child.

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11   Timelines are based on organizational context and capacity. Organizations should adapt timelines accordingly to fit context and needs.

The following Family Reunification and Tracing framework is adapted from the International Committee of the Red Cross (ICRC) Inter-agency Guiding Principles on UASC (2004) and serves as a guide:[12]

a) Registration and Documentation

1. Obtain consent from the child to carry out family reunification or tracing.

2. Compile and document all personal information on the child, including the following: full name, date and place of birth, father's and mother's name, siblings' names, ethnicity and religion, country of origin, former address in the village or town, last known location, and date of entry into Malaysia.

3. Information may be compiled from intake interviews already carried out with the child.

4. A child may not remember personal information; obtain as much information as possible. Wherever possible, photographs should be taken to help in the identification process.

5. Respect the confidential nature of information shared and all documentation must be stored in a confidential manner as prescribed in this Manual.

6. Carry out further interviews when necessary, as the child may recollect information over a period of time.

b) Tracing

1. Once some preliminary information has been collected, contact relevant implementing partners to coordinate tracing activities, including relevant community leaders and community based organizations, the UNHCR, the ICRC, the Red Cross, and relevant embassies, or government agencies, where appropriate. The suggested form in Annex 22 may be used to coordinate the information sharing process and to prevent the duplication of activities.

2. Note that the protection or safety of the child is of paramount importance. Although tracing should be proactive, continually assess if the tracing process is endangering the safety and well-being of the child or the child's family. If the child's safety is compromised, tracing should be delayed until a suitable time.

3. Ensure that the tracing approach is targeted and done in consultation with the child and all relevant implementing agencies. The child must always be kept informed of the tracing progress.

4. Tracing should continue until all reasonable efforts have been made to locate the family or relatives.

c) Verification and Family Reunification

1. Once parents or a caregiver has been identified, assess the veracity and validity of the person, and the willingness of all parties involved to be reunited. The assessment must also verify that reunification is in the best interest of the child.

2. In ideal circumstances, reunification should be with one or both parents. But in certain instances, reunification may be with other extended family members.

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12   Available at: https://www.icrc.org/eng/assets/files/other/icrc_002_1011.pdf.

3. In cases where the caregiver arrangement is inappropriate or not child friendly, reunification will have to be delayed. Actively work with the parents or caregivers involved to improve caregiver arrangements to ensure that the child will be protected. Referrals to other service providers may be required to assist families in these instances.

4. For children of migrant parents, and undocumented children, the reunification process may involve repatriation to a country where the parents or family members are now located. Work with IOM, ICRC, the Red Cross, relevant embassies and government agencies to ensure that the child is repatriated in adherence to all international guidelines on the repatriation of unaccompanied children.

5. For children who cannot be reunited with their families or where tracing falls through, alternative placement of care arrangements and durable solutions should instead be explored.

Stability and Permanency: Alternative Placement of Care

> **Where family reunification is not possible or is unsuccessful, secure alternative placement for care in the community via guardianship by relatives, informal foster care by community members, or independent living until adulthood. Carry out home visits, monitoring and work with families or caregivers to ensure that the caregiver arrangements are appropriate. Achieve permanent outcomes on placement within three months of placement.**

Where family reunification is not possible (such as where a child has escaped from his/her caregivers or country of origin due to safety issues), or is unsuccessful, intervention will include securing an alternative placement of care in the community. In each of these cases, explore the following community placement options in the following order:

1. Firstly, **guardianship and kinship care by relatives** or close family members in the community. This is usually often already being done in some form in the community and the monitoring of this relationship is needed to ensure that the placement is safe.

2. If there is no relative to care for the child, then consider placement in **foster care arrangements** by other community members. A separate section (page 62 onwards) in this Manual provides guidance on the processes on identifying, matching and placing a child in such care arrangements.

3. If options for placement with a relative or in foster care arrangements are unsuccessful, older children may be placed in **independent living group homes**. An assessment needs to be undertaken to determine which children should be placed in these peer-headed households. More support and supervision by the Case Managers will be required for this arrangement. House rules will also need to be developed and agreed on by the children living in the household. A sample is provided in **Annex 23**.

4. When community placement and independent living is not possible due to safety reasons, the final option for alternative care for a child may be a **shelter or residential care placement**. This placement option should ideally be temporary, pending more permanent solutions on care arrangements being developed.

Stability and Permanency: Legal Protection

Develop an intervention plan based on the child's profile, which includes referrals and periodic follow up to clarify a child's legal status. Legal protection will provide some permanency for a child's temporary stay in the country.

Based on information gathered during the intake phase, a specific intervention plan may be developed to address a child's lack of documentation or legal status. For children whose documentation status is not known, a suggested process is as follows:

1. Refer to a legal service provider for legal screening. Legal service providers will also assist in the preparations for the documentation process.

2. Refer to an authority who is able to ascertain the legal status of the child and provide some form of documentation; such as the UNHCR for refugee and asylum seeking children, embassies for migrant children, and, in some cases, government authorities, where necessary.

3. Referrals made must be assessed on whether it is in the best interest of the child and whether it meets confidentiality and safety requirements.

4. Follow up on the progress of these referrals on a regular basis.

Stability and Permanency: Longer-term Durable Solutions

Longer term solutions are developed in consultation with the child and based on the child's legal status. In some country context, longer term solutions are limited. A child should be prepared for independent living when ageing out of the programme.

Depending on the country context and legal status of the child, longer term options may include:

1. Resettlement for refugee and asylum seeking children.

2. Repatriation home following family reunification and/or when it is safe for a return.

3. Preparation to live independently when a child turns 18 and ages out of the case management programme.

To determine suitable options, a best interest determination should be carried out, weighing the circumstances and the wishes of the child. Development of longer term solutions must be planned in consultation with the child.

Child Well-being: Material Well-being

All food provided should be nutritious, suitable for consumption and in line with the child's dietary needs. The child should have adequate access to basic welfare needs, including food, clothing and sanitary items.

A key intervention would be ensuring that a child's material needs are adequately attended to following community placement. These needs may include: food, clothing, shoes, sanitary and hygiene items, and bedding. The provision may be one-off or on a regular or monthly basis. A suggested process framework may be as follows:

1. Identify the material needs of the child during the intake and care planning phase.

2. Identify relevant service providers to meet those needs or source relevant items to be provided by the organization.

3. Identify the amount and period of provision. Ensure all items are in good condition and meets the needs and religious or cultural preference of the child.

4. All food provided must be nutritious, suitable for consumption and in line with the child's cultural, religious and other dietary needs.

5. Regularly deliver relevant items to the child when necessary and without delays.

6. Regularly follow up on the material needs of the child.

Child Well-being: Physical Health

The client should have access to appropriate health care services, including dental services, provided at the appropriate time and without delays.

Based on the health needs identified during the intake phase, an appropriate intervention plan should be developed to address these and any other physical health needs of a client. In general, interventions should ensure a child is healthy and has adequate access to health care services. The following processes are recommended:

1. Identify past or current physical health needs of the client during intake. A sample physical health assessment checklist is also provided in **Annex 24**.

2. Refer the client to relevant healthcare services for a general health check to identify health needs or to confirm a particular health issue.

3. Follow up on the recommended intervention plan from the healthcare professional, including specialized follow up treatment or tests, when necessary.

4. Ensure there is sufficient financial means to implement the recommended intervention plan.

5. Clearly document and ensure continuous monitoring of treatment and follow up visits until the health concern is resolved.

6. Where necessary, a treatment and medication plan should be developed and updated accordingly with the child (see **Annex 25**).

Child Well-being: Emotional and Mental Health

The client has access to appropriate mental health services and other psychosocial support services on time.

Based on mental health needs identified during intake, appropriate intervention plans should be developed to assist the child in achieving stable mental and emotional health. The following processes may be initiated:

1. Refer the child for a general mental health assessment by a mental health professional.

2. Develop an intervention plan based on the recommendations from the mental health professional.

3. Obtain consent from the child before any assessment or treatment is carried out.

4. Follow up on all necessary counselling or therapy sessions and prescribed treatment, including any specialized tests or assessments, as needed.

5. Ensure continuous monitoring of the child's mental health and documentation of follow up visits for therapy, where necessary.

6. Encourage the child to participate in regular or periodic age appropriate psychosocial activities carried out by the community or other service providers.

Child Well-being: Education

The client has access to educational services, life skills opportunities and other skills-based learning.

The intervention plan should ensure that a child has adequate access to formal or informal educational opportunities and other skills-based learning to prepare the child for independent living. Educational opportunities should be in line with the age and developmental level of the child.

A suggested process framework may be as follows:

1. Identify relevant service providers located near the child who is able to provide educational services that meets the child developmental level.

2. Refer and liaise with a relevant educational centre for enrolment. A sample intervention referral form is provided in **Annex 20**.

3. Ensure the child has all relevant items to attend school, such as books, stationery, school uniform set, etc.

4. Regularly follow up on the child's progress in school and seek help from teachers and the foster parents or caregivers to assist as well with the follow up.

5. Where no educational opportunities are readily available, be proactive and engage volunteers or set up an independent programme for the child to learn, at the very least, English and Mathematics.

Child Well-being: Adequate Housing

The child has access to safe and suitable housing. Risk and safety assessment should be completed and safety plans developed accordingly.

A child must have a safe and suitable place to stay. A suggested process framework to ensure a child has appropriate housing is as follows:

1. Conduct a risk and safety assessment of the house and the surrounding environment as per the checklist in **Annex 26** to determine if the housing is suitable.

2. Where necessary, work with the caregivers and foster parents to ensure that the housing and living conditions are adequate for the child.

3. A safety plan should be developed with the foster parents or caregiver, and the child (see **Annex 21**).

4. In situations where efforts have been made to improve conditions, but the housing conditions still are below minimum standards, determine if it is in the best interest of the child to be moved to a more appropriate housing and living condition.

Child Well-being: Relationships and Support Systems

The client has access to a strong support system and to positive relationships.

Ensuring that the child has a strong support system and positive relationships is integral in meeting well-being goals.

Suggested initiatives include:

1. Identify the positive support systems and relationships in the child's life.

2. Encourage the child to build or develop these support systems.

3. If there is no support system, identify and refer the child to support groups and community groups that can be a support for the child.

4. Conduct three interaction activities a year for the children in the programme to foster relationships and to build a support system among the children in the programme.

Child Well-being: Risk and Safety

The client is safe from risk or threat of harm and incidences of arrest by authorities. A safety plan is developed.

This goal focuses on the risk and safety of the child at the hands of the State and non-State actors as a result of the child's legal status and reason for leaving his or her country of origin. This goal is different from the first goal of safety as it focuses more on the arrest, detention and community violence against the child rather than safety within a caregiver or housing situation. As such, based on the needs of the child, interventions may be needed to address the risks and safety of the child with regards to the risk of victimization or threat of violence in the community, and/or incidences of arrest by the authorities. A safety plan should be developed with the foster parents or caregiver and the child in case of such risks (similar to the section on *Adequate Housing* above).

1. Conduct a risk and safety assessment of the community and surrounding area. Identify all potential risks and threat of harm in the child's life.

2. Develop a safety plan with the caregivers or foster parents to mitigate the risks.

3. Where efforts have been made to mitigate risk but the threat of harm is still present, a review of the current placement is to be conducted. Consideration should be made as to whether a child will need to be moved to a safer location because of the threat of harm.

Phase 7: Monitoring and Reassessment

> **Monitoring and reassessment is conducted for each case. The frequency of the Case Managers' follow up differs, depending on what stage the case is at. Case Managers should meet clients at least once a month to review the progress of the care plan. Case Conferences and periodic monitoring of cases must be carried out accordingly. Monitoring and reassessment documentation by the Case Managers should be accurate and up-to-date.**

Monitoring and reassessments of care plans are carried out with the child's help to identify the progress in achieving goals, the efficacy of interventions, the priorities, and the necessary next steps. Monitoring is an ongoing and active process that constantly helps to inform the child, Case Manager, foster parents or caregivers, service providers, and other implementing agencies about the progress, gaps and areas for change. The monitoring and reassessments process may be case specific; however a general suggested monitoring framework is as follows during a case cycle:[13]

	Case Manager checks with the child	Team Case Review[14]	Case Committee Review
1-12 weeks (1st-3rd month)	bi-weekly	once in three weeks	once a month
13-36 weeks (4th–9th month)	monthly	monthly	once in two months
37 weeks onwards (10th month onwards)	monthly	initially monthly; subsequently, bi-monthly	once in three months
6 months before termination	monthly	monthly	once in two months
Post termination follow up for 6 months	monthly	once in three months	once in three months

A suggested process framework is as follows:

1. During the first 12 weeks of admission of a case, Case Managers should monitor the case and the community placement on a bi-weekly basis.

2. Any new community placement should also be monitored on a bi-weekly basis for 12 weeks. A monitoring checklist is provided in **Annex 27**. After the 12 weeks, a best interest assessment should be conducted on the placement.

3. Following a case stabilizing (usually after three months), Case Managers should conduct monthly home visits and checks to review the care plan. During these home visits or checks, Case Managers should follow up on progress of the care plan, as well as investigate any other new issue pertaining to the case management goals (see **Annex 27 and 28**).

4. If a child is placed with foster parents, Case Managers should also meet the foster parents to discuss any issues pertaining to the child's care plan, personal development and the foster care arrangement.

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13   The monitoring framework which is suggested is based on the current organizational practice and complexities of the case. Organizations should develop a framework best suited to their needs.

14   The team here usually involves Case Managers and the Case Supervisor. When the Case Supervisor is not available, the Project Director assists.

5. Team Case Review meetings should be conducted with Case Managers and the Case Supervisor to review each care plan. A monitoring review will determine the following:

   a. Whether care plan goals remain relevant.
   b. Whether the care plan and list of service providers are meeting the needs of the child.
   c. Whether there are any changes to the child's situation or environment.
   d. Whether interventions have aided goals achievement, and the impact of these goal achievements.
   e. Whether strategies are adequately resourced and all partners are contributing towards the goal achievement.
   f. Whether Case Managers are complying with timelines in implementing the care plan.
   g. Whether the child is cooperating in carrying out the care plan.

> If a child is placed in a foster care arrangement, monitoring and reassessment of the care plan must also be done with the foster parents. As the foster parent lives with the child on a daily basis, the foster parent is in a better position to provide information about any changes in the child's life and the impact of interventions carried out. Case Managers should conduct regular meetings with the foster parent to understand how the child is coping in the placement.

6. Case Committee Reviews must also be carried out via the Case Conference method. The Case Committee will review a child's progress or the barriers to the attainment of goals, the Case Managers' conduct and interventions, conflict or crises resolutions, and identify solutions for any concerns raised in managing a case. Case conference discussion and related decisions are documented in the form in **Annex 13**.

7. Case Managers must ensure that monitoring and reassessment documentation is accurate and up-to-date. Case progress should be documented using **Annex 27 and Annex 28.** Furthermore, the last two columns in the Full Client Individualized Care Plan Template **(Annex 17)** provides for the collection of information under this monitoring exercise. Where goals and strategies are reassessed, the Case Manager, client (and where necessary, the foster parents), will jointly develop a new care plan.

Phase 8: Termination and Case Resolution

> **A case is terminated under specified conditions. The client exit form is completed by the Case Manager, client or caregiver/guardian before the case is officially closed. The client also fills in a client feedback form. A debriefing is conducted with the Case Manager and Case Supervisor and the necessary documentation or case notes should be completed for reporting.**

Termination of a case may occur under one or more of the following circumstances:

- A durable solution is achieved (voluntary repatriation or resettlement).
- Family reunification.
- Aging out upon the client turning 18 (subjected to the relevant transition process).
- The client voluntarily terminates.
- Termination by the organization.
- Upon death of the client.

In instances where contact is lost with the child, the case remains inactive with the possibility of being re-opened once contact is made. The case will only be automatically closed six months later or sooner where information on termination is received.

In all cases of termination, the following should be carried out:

1. A client exit process form (using **Annex 29**) is completed with the child and/or caregiver or foster parents before the case is officially closed.

2. A client feedback form (**Annex 30**) is completed.

3. An exit letter or termination letter is issued, and, in some instances, a recommendation letter (samples in **Annex 31 and 32**) is completed to assist the child with future endeavours.

4. A final debriefing between the Case Manager and the child is carried out. In some cases, this debriefing is also done with the foster parent.

5. A debriefing between the Case Manager, Case Supervisor and Project Director is conducted and the necessary documentation or case notes should be completed for reporting.

For children placed in foster care arrangements, the termination process can also impact the foster parents. Case Managers need to be mindful that termination can be a difficult process especially if a bond has developed between the child and the foster parent. It is recommended that debriefings and feedback sessions are also done with the child and the foster parent where suitable. Case Managers can also encourage the foster parent to continue to guide and keep in touch with the child upon exit, particularly for children who age out into independent living.

a) Durable Solution (Resettlement or Repatriation)

1. Liaise with the relevant agencies involved, such as the relevant embassies, UNHCR and IOM.

2. Assist the child to prepare for resettlement or repatriation in any way deemed necessary, such as providing recommendation letters that may be helpful for the child to get a job or attend school in the new country, obtaining clothing for the child that is suitable for the new climate or travel luggage for the child to pack his/her belongings.

3. For a child who is being resettled, enrolment in language classes may be needed if he/she does not yet speak the country's language.

4. For a child who is being repatriated, ensure that the repatriation is carried out in a child friendly manner that avoids exploitation and the risk of trafficking.

b) Family Reunification

In some situations, the child's immediate family members may have arrived in the country after the child is in the programme, or there may be successful tracing and family reunification following a separation from the family unit in the country. The following are relevant processes to be initiated following such situations:

1. Following successful tracing and family reunification intervention (highlighted above under Phase 6), assist the child with the transfer to stay with the family.

2. Continue to monitor the placement on a monthly basis for six months to ensure it is in the best interest of the child to live with the family.

3. Support the child's family to care for the child by referring the family to relevant service providers who can help address their needs.

c) Aging Out

In instances where a child reaches the age of 18 but has no other durable solution, a transition phase will be initiated to prepare the child to exit from the programme. This transition phase ensures that a child is ready to exit the programme as all the needs currently being addressed via case management should be taken care of without case management interventions when the child exits. To prepare a child to exit the programme, these interventions may be initiated:

1. Provision of English classes and other skills based or vocational training classes to prepare the client for job placement.

2. Securing suitable job placements for the client, or developing sponsorship programmes for the client when he/she is unable to work or provide for him or herself.

3. Preparing the client to leave foster care arrangements by obtaining alternative housing and learning skills to live independently.

Once a client turns 18 the following is initiated:

1. A six-month transition phase where the client continues to be assisted to become self-sufficient.

2. Following this transition phase, a review will be conducted by the Case Committee to ascertain if termination is possible or an extension of the phase is needed.

3. Once termination is recommended, a three-month and six-month frequency of follow up will be undertaken to ensure that the client is still safe and adjusting well in the community.

d) Client voluntary termination

In some situations, the child may decide to leave the programme before case resolution is reached. The following should be carried out when a child expresses the wish to exit the programme:

4. Organise a meeting with the child to understand the situation better.

5. The child's situation is reviewed at a Case Conference to determine if termination is in the best interest of the child.

6. If it has been agreed for the child to leave the programme, inform the foster parents of the decision and the plan to help the child transition out of foster care.

7. Refer the child to speak to a counsellor or psychologist, where necessary, to help with the transition or to address any concerns.

8. If the decision is that it is not in the best interest of the child to exit the programme, advise the child accordingly, explaining why it is not in the child's best interest to do so.

9. Review the care plan and develop new interventions to address the concern that it is not in the best interest of the child to exit the programme.

10. Make arrangements for the child to speak to a counsellor or psychologist to help him/her understand this decision and work through any underlying issues.

11. If the child is adamant on leaving despite the decision, respect the decision to leave, but continue to monitor the child's situation to ensure safety for the child.

12. The child should be given the option to re-enter the programme within three months from termination if the child changes his/her mind about termination.

e) Termination by the organization

In some situations, the organization may determine that it is no longer in the best interest of the child to be in the programme. In such situations, it is important the following is carried out:

1. Ensure that the decision to terminate has been reached unanimously at a Case Conference meeting after weighing the impact of the decision and withdrawal of services on the child.

2. Inform the child promptly of this decision and develop a transition plan for the child to exit the programme.

3. Inform the child's foster parents of the same decision, if the child had been placed in foster care.

4. Provide the child with the opportunity to appeal the decision in writing. An appeal must be reviewed by different Case Committee members in a fair and objective manner.

5. If the decision to terminate remains, make arrangements for the child to transition out, similar to the Aging out process stated above.

f) Upon the death of the child

If, due to some unforeseen circumstances, the child dies during his or her placement in the programme, the following should be initiated:

6. Report to the authorities of the death with the relevant details.

7. Cooperate with the authorities on any investigations conducted, if needed.

8. Report the death to the child's next of kin.

9. Conduct an internal review and investigation on the circumstances of the death and review necessary protocols and procedures to avoid a similar unfortunate situation.

10. Arrange for the child's burial, based on the family's wishes and cultural or religious preference of the child.

11. Debrief with the other children in the programme and the foster parents of that child.

12. Debrief with the Case Manager, Case Supervisor and Project Director on the loss. Complete relevant documentation and incident reports accordingly.

13. Refer a counsellor or psychologist to help all persons in the child's life to deal with the loss.

THE COMMUNITY PLACEMENT PROCESS: FOSTER CARE

Foster Care Community Placement

- Screening
- Intake
- Training
- Selection
- Matching
- Orientation
- Care Planning
- Preparation for Exit
- Exit and Follow Up

Matching conducted if a child is assessed to be placed with a foster family

To be conducted with foster parents if a child is placed with a foster family

Collaboration between foster parents and case managers to implement the care plan by providing feedback, supporting the care plan and preparing the UASCfor exit

Case Management

#CM12345

- Referral
- Screening
- Rapport Building and Intake
- Assessment
- Rapport Building and Care Planning
- Implementation of Care Plan
- Monitoring and Reassessment
- Termination and Case Resolution
- Transition Phase for Aged Out UASC

To be conducted with foster parents if a child is placed with a foster family

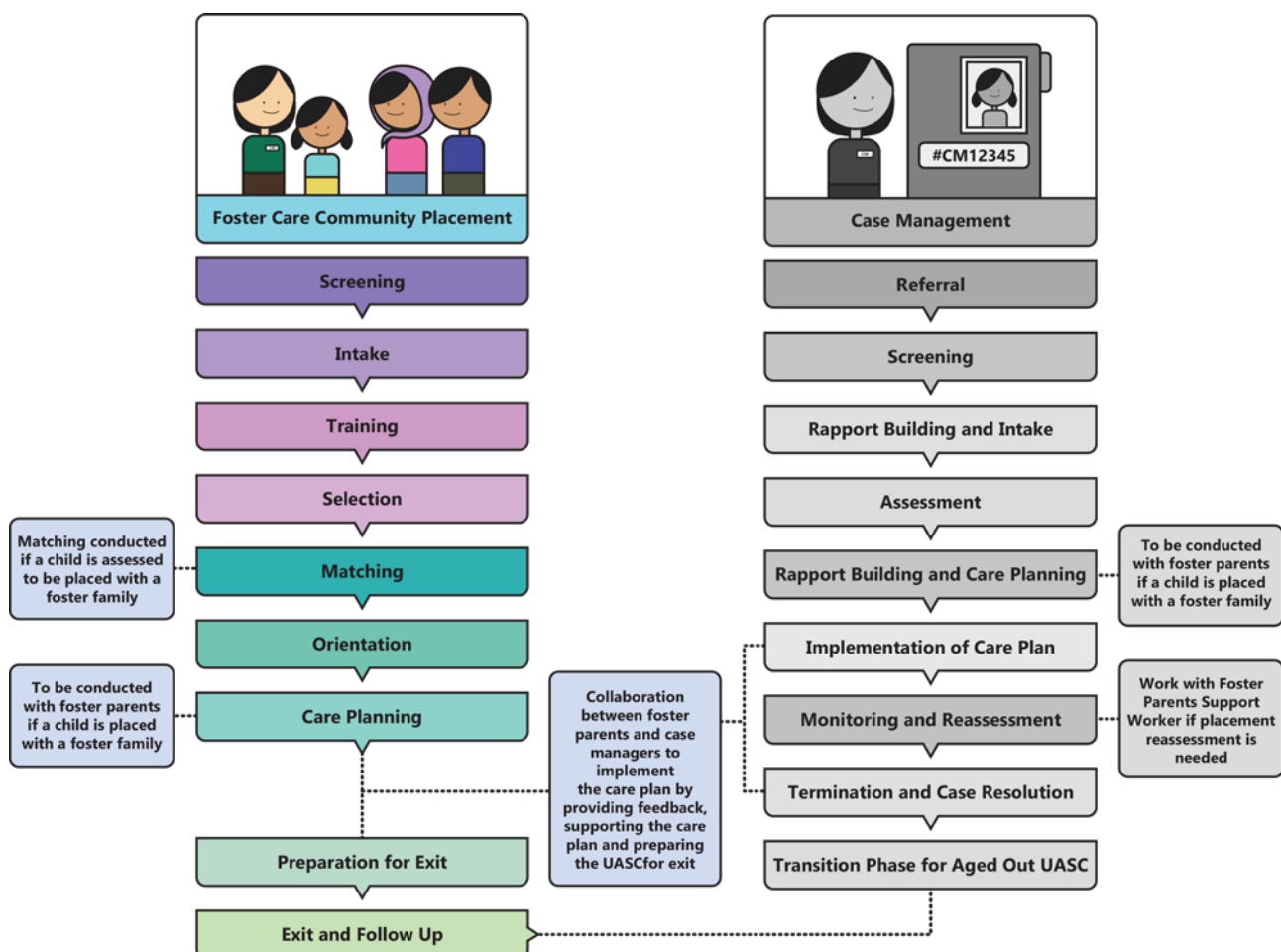Work with Foster Parents Support Worker if placement reassessment is needed

Figure 10 Flowchart highlighting the foster care community placement process for foster parents and sections where the process merges with a case management process

F. THE COMMUNITY PLACEMENT PROCESS: FOSTER CARE

INTRODUCTION[15]

1. Definition

Foster care refers to temporary care provided when a parent, legal guardian or customary care provider is unable to care for a child. A foster parent may be related or unrelated to the child. The goal of foster care is to provide a safe and nurturing home for the child to help limit the disruption in a child's life. Unlike adoption, in which the rights and responsibilities of the child's birth parents are legally terminated and transferred to the adoptive parents, the foster parents do not have the same parental rights over the foster child as the birth parents.

Formal Foster Care

Formal foster care typically occurs when the court grants the State the right to take temporary custody of the child and to arrange for relevant foster care arrangements accordingly. The State's child protection authority is responsible for the oversight of the foster care placement and ensures that the placement is safe and meets state foster care regulations and child welfare laws. The children's court/family court ensures that all relevant laws and procedures are observed and that rights of all parties are protected. The change of care must be legally authorized and regulated by the State or a foster care agency. Countries with formal foster care have clear legislation, guidelines and policies that govern such arrangements. There must be adequate documentation before a transfer of care can happen within a formal foster care arrangement. Benefits to such formal foster care arrangements include proper monitoring and regulation of care arrangements.

GUARDIANSHIP OF UASC

Generally, there is no commonly accepted definition of a guardian. The focus therefore, has mainly been on the functions of such appointed persons. Paragraph 33 of the UN Committee on the Rights of the Child, General Comment No. 6 (2005), describes the roles and responsibilities of such a guardian for UASC. Paragraph 19 of the UN General Assembly Guidelines for the Alternative Care of Children (2010) include provisions aiming to ensure that there is always a legally recognised person or body holding legal responsibility for the child when parents are absent. UN guidelines also recommend that a guardianship system should be an integral part of the national child protection system and operate within law and policy. In the Malaysian Child Act 2001, a guardian is defined as "*any person who, in the opinion of the Court for Children having cognizance of any case in relation to the child or in which the child is concerned, has for the time being the charge of or control over the child*".

According to the Malaysian Child Act 2001, a child is in need of care and protection if a child has no parent or guardian (Section 17(1) (e)). In situations where there is no parent or guardian, the State assumes temporary custody until transferred by the Courts. The State, under the Act, will make legal decisions for the child when needed (e.g. consent for medical procedures). The Court for Children may make an order to place unaccompanied children in the care and custody of a foster parent found to be suitable by the Director General of the Department of Social Welfare or in the care of a fit and proper person (Section 28(a)(ii) of the Child Amendment Act 2016 in reference to Section 30(1) (e) of the Child Act 2001).

However, at the point of writing, most refugees, asylum seeking and migrant unaccompanied children do not have access to these provisions. As a result, these communities practice informal foster care for UASC, particularly kinship care. Such private arrangements are not reported to the Department of Social Welfare and there is no legal transfer of custody through the courts. Similarly, under SUKA's programme, there is no transfer of custody through a court process.

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15   Information in this section has been adapted from the Manual on Foster Care for Unaccompanied and Separated Children and the Handbook for Foster Care Agency, developed jointly by UNHCR Malaysia and SUKA Society, April 2018. The Manual and Handbooks are available at: http://www.sukasociety.org/resources/foster-care-manual-handbooks.

Informal Foster Care

Informal foster care is a private and temporary arrangement between a child's parents and another party, who is usually a family member, a relative or family friend. This transfer is not overseen by the State or a family court. There is no change in legal responsibilities which remain with the child's parents. The parents retain the right to make all major decisions pertaining to the child. Kinship care is a type of informal foster care. Kinship care occurs when a family member or relative, or person from similar social origin, tribe or community agrees to care for a child on behalf of the parents. The arrangement is done without the involvement of a third party or the State. Fostering by kinship care may also happen spontaneously or unexpectedly in emergency cases when a family accidentally comes across a child who happens to be unaccompanied or separated and they decide to offer temporary care. There are many benefits to informal kinship care, including the ability for the child to maintain familial and community roots.
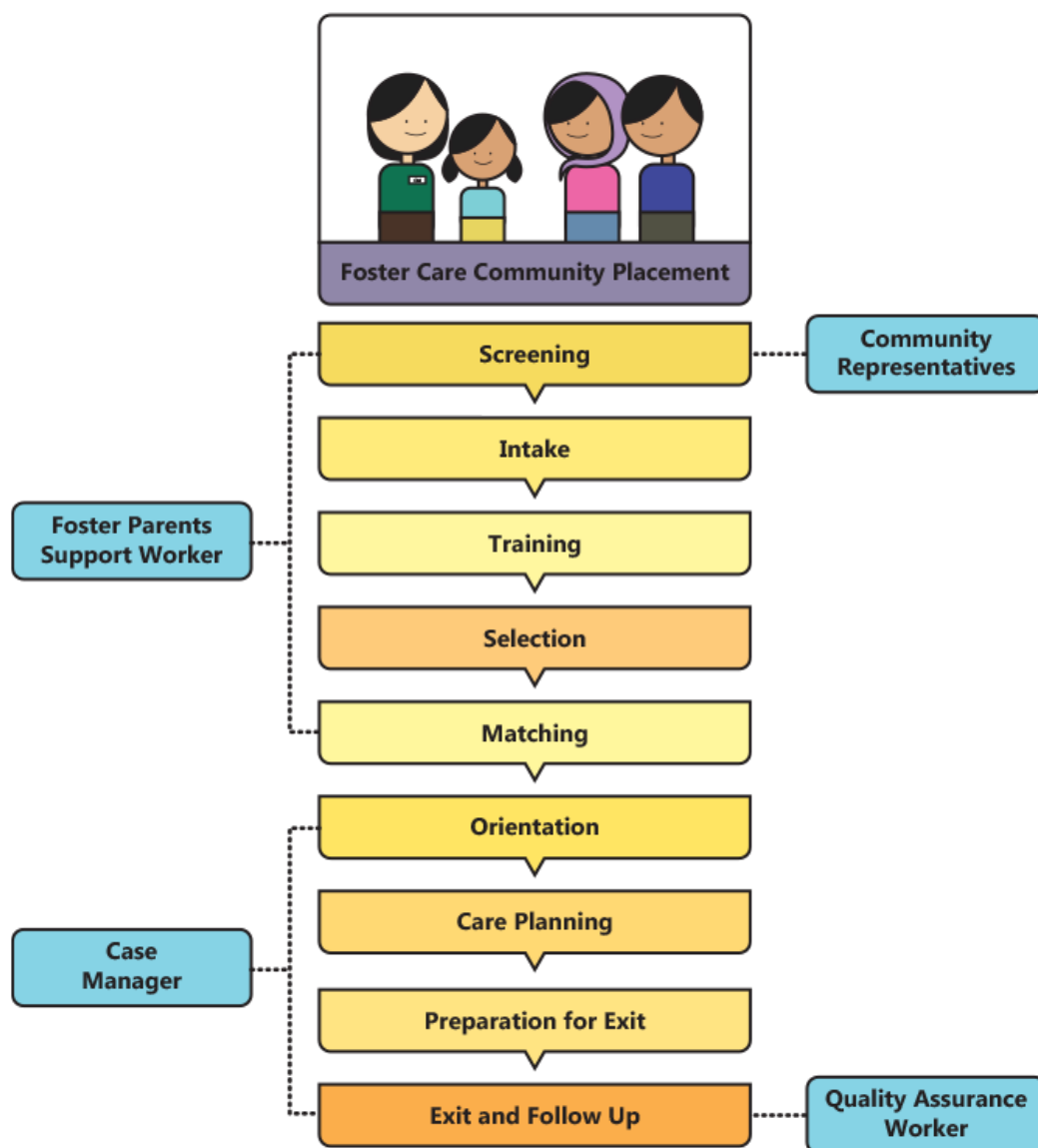
2. Key Stakeholders

Figure 11 Key stakeholders in a foster care community placement process for foster parents

Key stakeholders specifically involved in a foster care arrangement include:

a. Foster Parents – the UN General Assembly's Guidelines for the Alternative Care of Children considers a foster parent as someone other than the child's own family and customary care provider with whom the child has been placed by a competent authority to be cared for in a home or family environment.

b. Unaccompanied child – a person below the age of 18 and as defined in Article 1 of the UNCRC, as being separated from both parents and other relatives, and is not being cared for by an adult who, by law or custom, is responsible for doing so.

c. Foster Parents Support Worker – personnel of an agency who support the foster parents through home visits and counselling, and recommend ways to work with the child. The Foster Parents Support Worker may also be responsible for selecting and matching foster parents with a foster child.

d. Quality Assurance Worker – personnel of the agency who are responsible in assessing, monitoring and evaluating each foster care placement individually, and also the overall foster care programme.

e. Case Manager – personnel of the agency that provides case management services. Case Managers are responsible for assisting the child with the foster care placement and the monitoring of the placement.

f. Community Representatives - typically a leader from the community the child and/or foster parents are a member of. The community representative plays a crucial role in helping the foster care personnel link up with the community for the purposes of recruiting potential foster parents, receiving referrals, and developing community integration and support for the child.

Roles and responsibilities of some of these key stakeholders are available in **Annex 33**.

3. Minimum Standards of Care in Foster Care

Minimum standards of care in foster care ensure that the fostering service meets programme goals of safety, stability and well-being. The standards ensure that a child's rights are respected, protected and fulfilled, and allows the programme to maintain a consistent standard of quality in care among all relevant stakeholders. This ensures that a child in foster care placement have all their basic rights and needs fulfilled. Relevant stakeholders should strive to go above and beyond the minimum standards. A list of minimum standards of care in a foster care arrangement is provided in **Annex 34**.

FOSTER CARE PROCESS

1. Screening of Foster Parents

The screening process involves a preliminary screening of the potential foster parents. The primary focus of this process is safety, and therefore, to screen out persons whom an organization cannot be reasonably confident will be able to provide safe living arrangements for a foster child. It is important to ensure that the right persons are referred as potential foster parents. A suggested process framework is as follows:

1. Organize briefings for potential foster parents on what foster care is about and the processes involved in becoming a foster parent. Other partner agencies may also refer potential foster parents for consideration.

2. Potential foster parents must fill in a Foster Parents Application Form (refer to **Annex 35**) and submit it directly to the organization or through a community representative.

3. In the Foster Parents Application Form, potential foster parents will be asked for two referees who will need to write a reference for the foster parents.

4. Contact the two referees and request them to fill up the Foster Parents Reference Form (refer to **Annex 36**). The referees should not be related to the potential foster parents but should have sufficient knowledge of them and willing to be honest and open in providing comments about them.

5. Once both referees have returned the Foster Parents Reference Form, determine if the potential foster parents fulfil the basic criteria and safety requirements to become foster parents (refer to **Annex 37** for the Basic Screening Criteria for Foster Parents in the Programme).

6. Make arrangements for an intake interview with the potential foster parents and their families who fulfil the basic criteria and all the safety requirements.

2. Intake of Foster Parents

During the intake phase, gather enough information about the potential foster parents to determine if they are able to provide care for the child and if they are willing to play that role. The intake process is important to ensure that the parents have the personal disposition and available resources to be foster parents and are aware of the heavy responsibility of being foster parents. A suggested process framework is as follows:

1. Conduct an intake interview with the potential foster parents and their family members based on the Foster Parents Intake Form (**Annex 38**).

2. Conduct the first home assessment to ascertain if the home and the neighbouring area is suitable for a foster child to be placed there.

3. After the home has been assessed, inform the foster parents of the areas in which they have met the requirements, and provide advice on the areas they would need to work on to achieve the required standards.

4. If the home has very low potential in meeting the expected standards (e.g., there are too many people living in the home, or the home is located in a dangerous area, or the home is very dirty and poorly maintained, etc.), there is sufficient reason to reject the application. If an application is rejected, politely explain the reasons to the foster parents and recommend ways to improve, if the foster parents still want to continue with the application.

> Home assessment factors – Observe if:
>
> 1. There is a suitable place in the home for the child, and there is enough lighting and ventilation.
> 2. There is basic sanitation, water and electricity available in the home.
> 3. There are cooking facilities in the home, fulfilling basic safety requirements.
> 4. The home is generally clean and suitable to live in.
> 5. The foster parents are the legal tenants of the home they are renting.
> 6. The neighbourhood is generally safe
> 7. The people in the household have any medical issues.
> 8. The home is also used as a place of business.
> 9. There are a number of people who drop by or live temporarily in the home.

5. Generally, it can be assumed that the higher the number of deficiencies in the home and neighborhood that is assessed, the lower the potential of the home being used for foster care, especially as more effort and resources are needed to fulfill the required standards. However, if the foster parents are willing to take the effort and use their resources to make the changes, continue to advise them until they are able to meet the standards.

6. With the information obtained from the intake interview and if the foster parents are willing to comply with the housing recommendations, the application can be approved.

7. Once the application is approved, inform the potential foster parents of the requirement to attend a series of training sessions to further equip them for the role before being considered for the selection process.

3. Training

The purpose of the training phase is to equip potential foster parents with the necessary skills and knowledge to take on the fostering role. During the training sessions, potential foster parents are provided a safe environment to participate actively, ask questions, voice their needs, and share with other foster parents their strengths and areas to improve. A suggested process framework is as follows:

1. Plan a series of training sessions, taking into consideration the time, length and location of the sessions so that the foster parents are able to attend. Take note of work schedules, risks and costs involved in travelling to the training venue, and the need for childcare. Identify potential foster parents with difficulties in attending or participating in the sessions and provide the necessary assistance accordingly.

2. Inform the potential foster parents of the date, time and venue of the training sessions.

3. Key topics which will be covered during the training sessions include:

   a. Minimum Standards of Care (found in the Manual)
   b. Basic listening and communication skills
   c. First aid and guide to healthy living
   d. How to keep children safe
   e. How to deal with strong willed children
   f. How to help children who have trauma
   g. Psychosocial development of a child, particularly teenagers
   h. Maintaining healthy parent-child relationships and developing positive parenting skills.

4. Throughout the training sessions, continue to assess if the participants have acquired the basic knowledge and necessary skills to provide at least the minimum level of foster care required.

5. Keep a record of attendance of the participants. On completion of all the required training sessions, present the participants with a certificate of participation but also inform the participants that this certificate of participation is not an acknowledgement that they have been selected to be foster parents. All potential foster parents will have to undergo a final selection process.

6. The trainer will complete a trainers report on each potential foster parent (see **Annex 39** for a Trainers Report template).

4. Selection

This is the phase when it is decided if a child can be entrusted into the care of potential foster parents, who not only should have adequate resources and the capacity to provide for the child holistically, but should also be well enough to look after the child. Each application should be assessed objectively and fairly. An extensive and accurate Home Study Report should be prepared to assist the decision making process. A suggested process framework is as follows:

1. Conduct a second visual assessment of the home to see if the house, living situation and family circumstances are still suitable for the programme and if the changes suggested during the first visit have been carried out.

2. If there are more adjustments or improvements to be made, the Foster Parents Support Worker will explain what needs to be done and support the potential foster parents, where needed, to make the changes. They will be given as much time and support as needed to make those necessary changes.

3. Conduct a final interview with the potential foster parents and their family.

4. Compile information gathered from all the interviews and home visits to develop a Home Study Report (see **Annex 40**).

5. The Home Study Report will be presented at a Selection Committee meeting. The composition of this Committee is to be determined based on the availability of resource persons. The Committee is tasked with deciding whether the potential foster parents should be selected to be part of a pool of foster parents ready to foster a child. Decisions are made based on the minimum standards attained and information contained in the Home Study Report.

6. Once the Selection Committee has approved the selection, assist the potential foster parents to undergo a medical check-up to confirm that they are free from any communicable diseases that could affect the child. Communicable diseases to be tested are those transmittable by air and through food such as:
    a. Tuberculosis
    b. Hepatitis B and C.

7. Once the foster parents have obtained the medical report to confirm that they are free of any communicable disease, they will be given a letter of acceptance. The foster family is now ready to be matched to a foster child.

8. If one or both of the foster parents is/are found to have a communicable disease, make a decision as to whether to withdraw their application from the selection or to continue with the process. If the foster family is withdrawn from the selection, refer the person with the communicable disease to relevant organizations that will assist with relevant medical care.

9. If the decision is made for the foster parents to continue with the process, support and assist foster parents in obtaining necessary treatment, or provide further training on guidelines to reduce the spread of the particular disease if it cannot be treated.

10. Where the Selection Committee has rejected the application, the potential foster parents will be given a letter stating the reasons for the decision. Potential foster parents may choose to appeal the decision in writing, stating the reasons why they should be selected for the programme. The decision of the Selection Committee after the appeal is final.

5. Matching

Every child has a different set of needs and this may mostly be met by a particular foster family as compared to another. Aspects to be considered during the matching phase include the child's age, gender, temperament, immediate and long-term needs, and personal circumstances; the foster family configuration, parenting and foster care experience, language and cultural compatibility with the child, location of the home, and availability at the time of placement. All these factors are to be considered and balanced against one another when matching decisions are made. A suggested process framework is as follows:

1. A Matching Committee is formed to review and select a foster family that best fits the profile of the child. The Matching Committee should, at the very least, consist of the Case Manager, the Case Supervisor, the Foster Parents Support Worker and an independent expert on child care.

2. Prior to the Matching Committee meeting, a recommended list of criteria the child would need in a home environment, or the type of foster parents needed, based on the intake information is prepared.

3. These criteria will be reviewed and a shortlist of recommended foster parents who are deemed best suited to the needs of the child is developed. The Matching Committee will identify the best foster parents who would fit the needs and best interest of the child.

4. Contact the chosen foster family and provide a brief verbal description of the foster child such as his/her biodata and other important background information. Risks and challenges in looking after the particular child, as well as the strengths the family has which can potentially be of help to the child should be highlighted. Allow the foster parents to express any concerns they may have.

5. Once the chosen foster parents are ready to continue with the process, arrange for the child to meet the foster family at their home. If the chosen foster parents are not ready to continue with the process, select the next foster family that best fits the profile of the child.

6. On the day of the child's visit to the foster family's home, introduce the child to the foster family and vice versa. Both the child and the foster family should get to know one another better during this meeting. The child will be taken around the home and see where he/she will be sleeping. Monitor the interactions between the child and the foster parents to generally assess if it is a suitable placement. There can be more than one visit organised if needed.

7. After the meeting give the foster parents time to discuss with the rest of their family members to decide if the child is a good fit for their family and if they wish to foster the child. At the same time, the child will also be given time to think if the family is a good fit.

8. If both parties are agreeable to the foster care arrangement, explain to the foster parents the terms and conditions, including the resources the organization is committed to provide, based on the foster family's available resources and the needs of the child.

9. Prepare a Foster Parents Agreement Form which will state all the terms and conditions. The form will be translated into the language the foster parents understand. If the foster parents agree to the terms and conditions, they will then enter into an agreement with the organization by signing the Foster Care Agreement Form (**Annex 41**). Once the agreement has been signed, make preparations for the child to move into the foster home.

6. Placement: Orientation and Rapport Building

This process prepares the family and the child for the move into the foster home. It is important to create a suitable environment for the child and the foster parents to build rapport and to be more at ease with each another's company. The main objective of the orientation is to allow the child and the foster parents to work out expectations, concerns and fears so that the fostering relationship starts on the right footing. A suggested process framework is as follows:

1. Before the child moves in, ensure that the child's living space is fully equipped, such as bedding and a cupboard to store the child's belongings.

2. Provide the foster parents with additional information about the child which they will need to know to help meet the child's needs and care plan, and clarify the roles and responsibilities of the foster parents.

3. Plan an agenda for the orientation session which is to be conducted on the day the child moves to stay with the foster family. The orientation session is an informal event to welcome the child into the foster home and to help make the child feel comfortable and at ease with his/her new family. A sample agenda may be as follows:
   - The foster family helps the child move his/her belongings into the room.
   - Everyone gathers in the living room for some light refreshments.
   - Make some introductory remarks and outline the agenda for the orientation.
   - Everyone introduces themselves, how they want to be called, and perhaps, say some fun facts about themselves.
   - Carry out some icebreakers to encourage everyone to communicate and interact with one another.
   - Invite the head of the household, to say something to the child on behalf of the family.
   - Depending on the age and personality, the child can also be invited to say something to the foster family.
   - Talk about the hopes and expectations for the child through this programme while reinforcing the goals of foster care.
   - Clarify roles within the family:
     + Who does what in the family
     + Who to ask permission from and for what purpose
     + How to introduce the child to people outside the family.
   - Clarify house rules, especially unspoken rules (which should be made explicit) including: access to food, bed time, meal times, television viewing, house chores, and curfew.
   - Establish routines by helping the child understand family daily routines, weekend schedules and family rituals.
   - Clarify any health issues, particularly chronic health concerns or disability, relevant medication to be taken and hospital appointments.
   - Clarify how the Case Manager will be involved in the placement.
   - Clarify any further questions the child or foster parents may have.
   - Closing remarks to end the session.

4. Carry out an orientation session based on the above agenda with the child and the foster parents.

5. After the session, make arrangements for the next home visit to be conducted approximately two weeks later.

G. CONCLUSION

Having provided the guide and recommended framework above to set up a Community Placement and Case Management Programme for UASC, there are some final important tips to remember when embarking on this journey.

- Take time and effort to understand your community and your clients. Ensure key staff involved in the project understands the needs of the community and the children they are serving.
- Know your staff capacity and limits. Invest time in staff welfare and ensure every staff is able to practice relevant self-care methods.
- A large part of the work involves mentorship and relationship building with the client, foster families, and the community.
- Always be open to feedback, change and continuous development. The nature of the Programme demands that processes and procedures are readily adaptable to the changing needs of the community and country context.
- Take time and effort to invest in, and build on partnerships with relevant stakeholders. No one organization can do this work alone.
- Remember that you are working with people. There is an integral human aspect to the work that must not be forgotten when implementing processes and procedures. It is not a mechanical process but a journey with the client.

Since undertaking this journey, SUKA Society has discovered that the effort and work put into this Programme has indeed been worthwhile. An external monitoring and evaluation was completed and the following are some key findings on the Programme:

Case management goals	Key findings from the evaluation
Safety	Of 50 cases included in this evaluation, 14 were assessed as being in imminent danger and 4 in present danger. Of the 4 categorized in present danger, 3 had immediate follow up within 24hrs and 1 had follow up within 48 hours. 100% of UASC reported increased feelings of safety and security as a result of programme participation.
Stability: Family tracing	Of the 50 cases included in this evaluation, only 4 were assessed as appropriate for referral to tracing services. Other cases were not referred for tracing as the child was in contact with family members, all family members were deceased, or that it was not in the child's best interest to reconnect with family members. Of the 4 cases referred to tracing services, 2 were successfully reconnected with lost family members.
Stability: Alternative care in the community	Of the 50 cases included in this evaluation, 36 were placed in foster care placements, 6 were in kinship care arrangements, and 8 were placed in independent living arrangements.
Permanency: Legal status	On intake, 44 out of 50 UASC were 'undocumented'. All cases were referred to UNHCR and not one client missed a UNHCR appointment. At the time of the evaluation, legal status was resolved for 43 clients, with one in the process of resolution
Permanency: Durable solutions	Of the 50 cases included in this evaluation, 12 were resettled, 12 were assisted with preparations for independent living, and 1 voluntarily returned home.
Well-being: Material aid and adequate housing	100% of children in the program received material assistance including rental support and monthly food aid.

Case management goals	Key findings from the evaluation
Well-being: Physical health	27 of the 50 UASC included in this evaluation were identified as being in need of health intervention. SUKA was able to support a total of 21 UASC to resolve their health issues while 3 cases remain in process of resolution. Only 3 cases remained unresolved due to a gap in expertise within country and/or prohibitively high treatment costs.
Well-being: Emotional and mental health	Of the 50 cases considered for this evaluation, 20 were identified as requiring mental health services. SUKA has been able to direct 16 clients into mental health care support while 4 clients declined consent to be referred.
Well-being: Education	Of the 50 cases included in this evaluation, 100% received an education assessment upon entry into the programme. From this, 88% are engaged in ongoing education. Only 6 UASC on the program were not engaged in education, while 4 had dropped out after initially attending. Two remain unable to attend due to access issues.

A full evaluation report and further advocacy documents on the programme will be accessible on the website: www.sukasociety.org